1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

```
                                               POSITIONS
            NAME                   TYPE  LENGTH BEG  END                        CONTENTS
   ---------------------------    ----  ------ ---------    -------------------------------------------------

 ****  FI OUTPATIENT CLAIM RECORD  REC    VAR              FISCAL INTERMEDIARY OUTPATIENT CLAIM RECORD FOR
                                                           VERSION I OF THE NCH.

                                                           STANDARD ALIAS: FI_OP_CLM_REC
                                                           SYSTEM ALIAS: UTLOUTPI

 ****  FI OUTPATIENT CLAIM FIXED   GROUP   595    1  595   FIXED PORTION OF THE FISCAL INTERMEDIARY OUTPATIENT
       GROUP                                               CLAIM RECORD FOR VERSION I OF THE NCH.

                                                           STANDARD ALIAS: FI_OP_CLM_FIX_GRP

 ****  CLAIM RECORD IDENTIFICATION GROUP     8    1    8   EFFECTIVE WITH VERSION 'I' THE RECORD
       GROUP                                               LENGTH, VERSION CODE, RECORD IDENTIFICATION,
                                                           CODE AND NCH DERIVED CLAIM TYPE CODE WERE MOVED
                                                           TO THIS GROUP FOR INTERNAL NCH PROCESSING.

                                                           STANDARD ALIAS: CLM_REC_IDENT_GRP

    1. RECORD LENGTH COUNT         PACK      3    1    3   EFFECTIVE WITH VERSION H, THE COUNT (IN BYTES)
                                                           OF THE LENGTH OF THE CLAIM RECORD.

                                                           NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                                  WAS POPULATED WITH DATA THROUGHOUT HISTORY
                                                                  (BACK TO SERVICE YEAR 1991).

                                                           5 DIGITS SIGNED

                                                           DB2 ALIAS: REC_LNGTH_CNT
                                                           SAS ALIAS: REC_LEN
                                                           STANDARD ALIAS: REC_LNGTH_CNT

                                                           SOURCE:
                                                           NCH

    2. NCH NEAR-LINE RECORD        CHAR      1    4    4   THE CODE INDICATING THE RECORD VERSION OF THE NEARLIN
```

```
     VERSION CODE                                          WHERE THE INSTITUTIONAL, CARRIER OR DMERC CLAIMS DATA
                                                           STORED.

                                                           DB2 ALIAS: NCH_REC_VRSN_CD
                                                           SAS ALIAS: REC_LVL
                                                           STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
                                                           TITLE ALIAS: NCH_VERSION

                                                           CODES:
                                                           A = RECORD FORMAT AS OF JANUARY 1991
                                                           B = RECORD FORMAT AS OF APRIL 1991
                                                           C = RECORD FORMAT AS OF MAY 1991
                                                           D = RECORD FORMAT AS OF JANUARY 1992
                                                           E = RECORD FORMAT AS OF MARCH 1992
                                                           F = RECORD FORMAT AS OF MAY 1992
                                                           G = RECORD FORMAT AS OF OCTOBER 1993
                                                           H = RECORD FORMAT AS OF SEPTEMBER 1998
                                                           I = RECORD FORMAT AS OF JULY 2000

                                                           COMMENT:
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                              POSITIONS
               NAME                TYPE  LENGTH BEG   END                         CONTENTS
     ---------------------------   ----  ------ ---------  ----------------------------------------------------
                                                           PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                           CLM_NEAR_LINE_REC_VRSN_CD.

                                                           SOURCE:
                                                           NCH

  3. NCH NEAR LINE RECORD          CHAR     1    5    5  A CODE DEFINING THE TYPE OF CLAIM RECORD BEING PROCES
     IDENTIFICATION CODE
                                                           COMMON ALIAS: RIC
                                                           DB2 ALIAS: NEAR_LINE_RIC_CD
                                                           SAS ALIAS: RIC_CD
                                                           STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD
                                                           TITLE ALIAS: RIC

                                                           CODES:
                                                             REFER TO: NCH_NEAR_LINE_RIC_TB
                                                                       IN THE CODES APPENDIX

                                                           COMMENT:
```

                                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                            RIC_CD.

                                                            SOURCE:
                                                            NCH

    4. NCH MQA RIC CODE   CHAR   1   6   6   EFFECTIVE WITH VERSION H, THE CODE USED (FOR INTERNAL
                                                            EDITING PURPOSES) TO IDENTIFY THE RECORD BEING PROCES
                                                            THROUGH HCFA'S CWFMQA SYSTEM.

                                                            NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
                                                                    FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSE
                                                                    TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

                                                            DB2 ALIAS: NCH_MQA_RIC_CD
                                                            SAS ALIAS: MQA_RIC
                                                            STANDARD ALIAS: NCH_MQA_RIC_CD
                                                            TITLE ALIAS: MQA_RIC

                                                            CODES:
                                                            1 = INPATIENT
                                                            2 = SNF
                                                            3 = HOSPICE
                                                            4 = OUTPATIENT
                                                            5 = HOME HEALTH AGENCY
                                                            6 = PHYSICIAN/SUPPLIER
                                                            7 = DURABLE MEDICAL EQUIPMENT

                                                            SOURCE:
                                                            NCH QA PROCESS

    5. NCH CLAIM TYPE CODE   CHAR   2   7   8   THE CODE USED TO IDENTIFY THE TYPE OF CLAIM RECORD BE
                                                            PROCESSED IN NCH.

                                                            NOTE1:   DURING THE VERSION H CONVERSION THIS FIELD WA
                                                                     POPULATED WITH DATA THROUGH- OUT HISTORY (BAC
                                                                     SERVICE YEAR 1991).
  1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                    POSITIONS
                    NAME   TYPE   LENGTH BEG   END   CONTENTS
          ----------------------------   ----   ------ --------   --

                                                            NOTE2:   DURING THE VERSION I CONVERSION THIS FIELD WA

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                                    EXPANDED TO INCLUDE INPATIENT 'FULL' ENCOUNTE
                                    CLAIMS (FOR SERVICE DATES AFTER 6/30/97).
                                    PLACEHOLDERS FOR PHYSICIAN AND OUTPATIENT ENC
                                    (AVAILABLE IN NMUD) HAVE ALSO BEEN ADDED.


                        DB2 ALIAS: NCH_CLM_TYPE_CD
                        SAS ALIAS: CLM_TYPE
                        STANDARD ALIAS: NCH_CLM_TYPE_CD
                        SYSTEM ALIAS: LTTYPE
                        TITLE ALIAS: CLAIM_TYPE


                        DERIVATION:
                        FFS CLAIM TYPE CODES DERIVED FROM:
                          NCH CLM_NEAR_LINE_RIC_CD
                          NCH PMT_EDIT_RIC_CD
                          NCH CLM_TRANS_CD
                          NCH PRVDR_NUM

                        INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                          (PRE-HDC PROCESSING -- AVAILABLE IN NCH)
                          CLM_MCO_PD_SW
                          CLM_RLT_COND_CD
                          MCO_CNTRCT_NUM
                          MCO_OPTN_CD
                          MCO_PRD_EFCTV_DT
                          MCO_PRD_TRMNTN_DT

                        INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                          (HDC PROCESSING -- AVAILABLE IN NMUD)
                          FI_NUM

                        INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                        FROM: (HDC PROCESSING -- AVAILABLE IN NMUD)
                          FI_NUM
                          CLM_FAC_TYPE_CD
                          CLM_SRVC_CLSFCTN_TYPE_CD
                          CLM_FREQ_CD
                        NOTE:  FROM 7/1/97 TO THE START OF HDC PROCESSING(?),
                        ABBREVIATED INPATIENT ENCOUNTER CLAIMS ARE NOT
                        AVAILABLE IN NCH OR NMUD.

                        PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                          (AVAILABLE IN NMUD)
                          CARR_NUM
```

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                                             CLM_DEMO_ID_NUM

                                         OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                           (AVAILABLE IN NMUD)
                                           FI_NUM

                                         OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                         DERIVED FROM:  (AVAILABLE IN NMUD)
                                           FI_NUM
                                           CLM_FAC_TYPE_CD
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                  POSITIONS
             NAME                 TYPE  LENGTH BEG  END                              CONTENTS
    ---------------------------- ----  ------ --------  --------------------------------------------------
                                                          CLM_SRVC_CLSFCTN_TYPE_CD
                                                          CLM_FREQ_CD

                                                        DERIVATION RULES:

                                                        SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                        FOLLOWING CONDITIONS ARE MET:
                                                        1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                        2.    PMT_EDIT_RIC_CD EQUAL 'F'
                                                        3.    CLM_TRANS_CD EQUAL '5'

                                                        SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                        1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                        2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                        3.    CLM_TRANS_CD EQUAL '0' OR '4'
                                                        4.    POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                                              OR 'Z'

                                                        SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                        1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                        2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                        3.    CLM_TRANS_CD EQUAL '0' OR '4'
                                                        4.    POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                                              OR 'Z'

                                                        SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
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                                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                        2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                        3.   CLM_TRANS_CD EQUAL '6'

                                                        SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                                        ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                        THE FOLLOWING CONDITIONS ARE MET:
                                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                        2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                        3.   CLM_TRANS_CD EQUAL '6'
                                                        4.   FI_NUM = 80881

                                                        SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                                        ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                                        1.   FI_NUM = 80881
                                                        2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                                             CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                                             CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                                                        SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                        2.   PMT_EDIT_RIC_CD EQUAL 'I'
                                                        3.   CLM_TRANS_CD EQUAL 'H'

                                                        SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
    1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                    POSITIONS
            NAME              TYPE  LENGTH BEG  END                              CONTENTS
    ---------------------------- ---- ------ --------- -------------------------------------------------------
                                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                        2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                        3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                                                        SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                                        CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                                                        12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                        1.   CLM_MCO_PD_SW = '1'
                                                        2.   CLM_RLT_COND_CD = '04'
                                                        3.   MCO_CNTRCT_NUM
                                                             MCO_OPTN_CD = 'C'
                                                             CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
```

```
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.    FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.    FI_NUM = 80881 AND
2.    CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
      TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O NON-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.    HCPCS_CD NOT ON DMEPOS TABLE

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.    HCPCS_CD ON DMEPOS TABLE (NOTE: IF ONE OR
       MORE LINE ITEM(S) MATCH THE HCPCS ON THE
       DMEPOS TABLE).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:
1.    CARR_NUM = 80882 AND
2.    CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M NON-DMEPOS DMERC
   CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2.    HCPCS_CD NOT ON DMEPOS TABLE

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
```

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   1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                 POSITIONS
                        NAME                  TYPE  LENGTH BEG  END                            CONTENTS
           ------------------------------     ----  ------ ---------   ------------------------------------------------
                                                                          1.    CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                                          2.    HCPCS_CD ON DMEPOS TABLE (NOTE: IF ONE OR
                                                                                MORE LINE ITEM(S) MATCH THE HCPCS ON THE
                                                                                DMEPOS TABLE).

                                                                       CODES:
                                                                         REFER TO: NCH_CLM_TYPE_TB
                                                                                   IN THE CODES APPENDIX

                                                                       SOURCE:
                                                                       NCH

     ****   FISCAL INTERMEDIARY CLAIM        GROUP   125    9   133   EFFECTIVE WITH VERSION 'I', THIS GROUP
            LINK GROUP                                                 CONTAINS THOSE FIELDS NECESSARY TO KEEP RECORDS/
                                                                       SEGMENTS TOGETHER (A CLAIM MAY HAVE UP 10 RECORDS/
                                                                       SEGMENTS DUE TO THE INCREASE IN NUMBER OF REVENUE
                                                                       CENTER TRAILERS (UP TO 450).  IT IS ALSO USED TO
                                                                       HOUSE FIELDS NECESSARY FOR SORTING AND FINAL
                                                                       ACTION PROCESSING.

                                                                       STANDARD ALIAS: FI_CLM_LINK_GRP

     ****   CLAIM LOCATOR NUMBER GROUP       GROUP    11    9    19   THIS NUMBER UNIQUELY IDENTIFIES THE BENEFICIARY IN
                                                                       THE NCH NEARLINE.

                                                                       COMMON ALIAS: HIC
                                                                       STANDARD ALIAS: CLM_LCTR_NUM_GRP
                                                                       TITLE ALIAS: HICAN

       6. BENEFICIARY CLAIM ACCOUNT          CHAR      9    9    17   THE NUMBER IDENTIFYING THE PRIMARY BENEFICIARY
           NUMBER                                                      UNDER THE SSA OR RRB PROGRAMS SUBMITTED.

                                                                       COMMON ALIAS: CAN
                                                                       DA3 ALIAS: CLAIM_ACCOUNT_NUMBER
                                                                       DB2 ALIAS: BENE_CLM_ACNT_NUM
                                                                       SAS ALIAS: CAN
                                                                       STANDARD ALIAS: BENE_CLM_ACNT_NUM
                                                                       TITLE ALIAS: CAN
```

```
                                            SOURCE:
                                            SSA,RRB

                                            LIMITATIONS:
                                            RRB-ISSUED NUMBERS CONTAIN AN OVERPUNCH IN
                                            THE FIRST POSITION THAT MAY APPEAR AS A PLUS
                                            ZERO OR A-G.   RRB-FORMATTED NUMBERS MAY
                                            CAUSE MATCHING PROBLEMS ON NON-IBM MACHINES.

   7. NCH CATEGORY EQUATABLE          CHAR    2    18   19  THE CODE CATEGORIZING GROUPS OF BICS
      BENEFICIARY IDENTIFICATION                            REPRESENTING SIMILAR RELATIONSHIPS BETWEEN
      CODE                                                  THE BENEFICIARY AND THE PRIMARY WAGE EARNER.

                                            THE EQUATABLE BIC MODULE ELECTRONICALLY MATCHES
                                            TWO RECORDS THAT CONTAIN DIFFERENT BICS WHERE
                                            IT IS APPARENT THAT BOTH ARE RECORDS FOR THE
                                            SAME BENEFICIARY.  IT VALIDATES THE BIC AND
   1               FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                    POSITIONS
          NAME                   TYPE  LENGTH BEG  END                        CONTENTS
   ----------------------------- ----  ------ --------  ----------------------------------------------------
                                            RETURNS A BASE BIC UNDER WHICH TO HOUSE THE
                                            RECORD IN THE NATIONAL CLAIMS HISTORY (NCH)
                                            DATABASES.  (ALL RECORDS FOR A BENEFICIARY
                                            ARE STORED UNDER A SINGLE BIC.)

                                            COMMON ALIAS: NCH_BASE_CATEGORY_BIC
                                            DB2 ALIAS: CTGRY_EQTBL_BIC
                                            SAS ALIAS: EQ_BIC
                                            STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD
                                            TITLE ALIAS: EQUATED_BIC

                                            CODES:
                                              REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
                                                        IN THE CODES APPENDIX

                                            COMMENT:
                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                            CTGRY_EQTBL_BENE_IDENT_CD.

                                            SOURCE:
                                            BIC EQUATE MODULE
```

```
8. BENEFICIARY IDENTIFICATION    CHAR     2    20   21   THE CODE IDENTIFYING THE TYPE OF RELATIONSHIP BETWEEN
   CODE                                                  INDIVIDUAL AND A PRIMARY SOCIAL SECURITY ADMINISTRATI
                                                         (SSA) BENEFICIARY OR A PRIMARY RAILROAD BOARD (RRB)
                                                         BENEFICIARY.

                                                         COMMON ALIAS: BIC
                                                         DA3 ALIAS: BENE_IDENT_CODE
                                                         DB2 ALIAS: BENE_IDENT_CD
                                                         SAS ALIAS: BIC
                                                         STANDARD ALIAS: BENE_IDENT_CD
                                                         TITLE ALIAS: BIC

                                                         EDIT-RULES:
                                                         EDB REQUIRED FIELD

                                                         CODES:
                                                            REFER TO: BENE_IDENT_TB
                                                                         IN THE CODES APPENDIX

                                                         SOURCE:
                                                         SSA/RRB

9. NCH STATE SEGMENT CODE        CHAR     1    22   22   THE CODE IDENTIFYING THE SEGMENT OF THE NCH NEARLINE
                                                         CONTAINING THE BENEFICIARY'S RECORD FOR A SPECIFIC SE
                                                         YEAR.  EFFECTIVE 12/96, SEGMENTATION IS BY CLM_LCTR_N
                                                         THEN FINAL ACTION SEQUENCE WITHIN RESIDENCE STATE.  (
                                                         TO 12/96, SEGMENTATION WAS BY RANGES OF COUNTY CODES
                                                         THE RESIDENCE STATE.)

                                                         DB2 ALIAS: NCH_STATE_SGMT_CD
                                                         SAS ALIAS: ST_SGMT
                                                         STANDARD ALIAS: NCH_STATE_SGMT_CD
                                                         TITLE ALIAS: NEAR_LINE_SEGMENT
```

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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                                           POSITIONS
            NAME                 TYPE  LENGTH BEG  END                         CONTENTS
   ----------------------------- ----  ------ --------  -----------------------------------------------------
                                                        CODES:
                                                           REFER TO: NCH_STATE_SGMT_TB
                                                                        IN THE CODES APPENDIX

                                                        COMMENT:
```

PRIOR TO VERSION H THIS FIELD WAS NAMED:
BENE_STATE_SGMT_NEAR_LINE_CD.

SOURCE:
NCH

10. BENEFICIARY RESIDENCE SSA   CHAR   2   23   24   THE SSA STANDARD STATE CODE OF A BENEFICIARY'S RESIDE
    STANDARD STATE CODE

                                                        DA3 ALIAS: SSA_STANDARD_STATE_CODE
                                                        DB2 ALIAS: BENE_SSA_STATE_CD
                                                        SAS ALIAS: STATE_CD
                                                        STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
                                                        TITLE ALIAS: BENE_STATE_CD

                                                        EDIT-RULES:
                                                        OPTIONAL: MAY BE BLANK

                                                        CODES:
                                                          REFER TO: GEO_SSA_STATE_TB
                                                                    IN THE CODES APPENDIX

                                                        COMMENT:
                                                        1. USED IN CONJUNCTION WITH A COUNTY CODE, AS
                                                           SELECTION CRITERIA FOR THE DETERMINATION OF
                                                           PAYMENT RATES FOR HMO REIMBURSEMENT.
                                                        2. CONCERNING INDIVIDUALS DIRECTLY BILLABLE FOR
                                                           PART B AND/OR PART A PREMIUMS, THIS ELEMENT
                                                           IS USED TO DETERMINE IF THE BENEFICIARY
                                                           WILL RECEIVE A BILL IN ENGLISH OR SPANISH.
                                                        3. ALSO USED FOR SPECIAL STUDIES.

                                                        SOURCE:
                                                        SSA/EDB

11. CLAIM FROM DATE   NUM   8   25   32   THE FIRST DAY ON THE BILLING STATEMENT
                                                        COVERING SERVICES RENDERED TO THE BENE-
                                                        FICIARY (A.K.A. 'STATEMENT COVERS FROM DATE').

                                                        NOTE: FOR HOME HEALTH PPS CLAIMS, THE 'FROM'
                                                        DATE AND THE 'THRU' DATE ON THE RAP (INITIAL
                                                        CLAIM) MUST ALWAYS MATCH.

                                                        8 DIGITS UNSIGNED

```
                                               DB2 ALIAS: CLM_FROM_DT
                                               SAS ALIAS: FROM_DT
                                               STANDARD ALIAS: CLM_FROM_DT
                                               TITLE ALIAS: FROM_DATE

                                               EDIT-RULES:
                                               YYYYMMDD
  1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                            POSITIONS
            NAME                    TYPE  LENGTH BEG  END                         CONTENTS
  ---------------------------      ----  ------ --------   ----------------------------------------------------

                                               SOURCE:
                                               CWF

  12.  CLAIM THROUGH DATE          NUM      8    33   40   THE LAST DAY ON THE BILLING STATEMENT COVERING
                                                           SERVICES RENDERED TO THE BENEFICIARY (A.K.A
                                                           'STATEMENT COVERS THRU DATE').

                                                           NOTE:  FOR HOME HEALTH PPS CLAIMS, THE 'FROM'
                                                           DATE AND THE 'THRU' DATE ON THE RAP (INITIAL
                                                           CLAIM) MUST ALWAYS MATCH.

                                                           8 DIGITS UNSIGNED

                                                           DB2 ALIAS: CLM_THRU_DT
                                                           SAS ALIAS: THRU_DT
                                                           STANDARD ALIAS: CLM_THRU_DT
                                                           TITLE ALIAS: THRU_DATE

                                                           EDIT-RULES:
                                                           YYYYMMDD

                                                           SOURCE:
                                                           CWF

  13.  NCH WEEKLY CLAIM PROCESSING  NUM     8    41   48   THE DATE THE WEEKLY NCH DATABASE LOAD
       DATE                                                PROCESS CYCLE BEGINS, DURING WHICH THE CLAIM
                                                           RECORDS ARE LOADED INTO THE NEARLINE FILE.
                                                           THIS DATE WILL ALWAYS BE A FRIDAY, ALTHOUGH
                                                           THE CLAIMS WILL ACTUALLY BE APPENDED TO THE
                                                           DATABASE SUBSEQUENT TO THE DATE.
```

```
                                         8 DIGITS UNSIGNED

                                         DB2 ALIAS: NCH_WKLY_PROC_DT
                                         SAS ALIAS: WKLY_DT
                                         STANDARD ALIAS: NCH_WKLY_PROC_DT
                                         TITLE ALIAS: NCH_PROCESS_DT

                                         EDIT-RULES:
                                         YYYYMMDD

                                         COMMENT:
                                         PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                         HCFA_CLM_PROC_DT.

                                         SOURCE:
                                         NCH

   14. CWF CLAIM ACCRETION DATE    NUM    8   49   56   THE DATE THE CLAIM RECORD IS ACCRETED (POSTED/
                                                        PROCESSED) TO THE BENEFICIARY MASTER RECORD
                                                        AT THE CWF HOST SITE AND AUTHORIZATION FOR
                                                        PAYMENT IS RETURNED TO THE FISCAL INTERME-
                                                        DIARY OR CARRIER.

                                         8 DIGITS UNSIGNED
1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                               POSITIONS
             NAME                TYPE  LENGTH BEG   END                           CONTENTS
   ----------------------------- ----  ------ --------   ------------------------------------------------

                                         DB2 ALIAS: CWF_CLM_ACRTN_DT
                                         SAS ALIAS: ACRTN_DT
                                         STANDARD ALIAS: CWF_CLM_ACRTN_DT
                                         TITLE ALIAS: ACCRETION_DT

                                         EDIT-RULES:
                                         YYYYMMDD

                                         SOURCE:
                                         CWF

   15. CWF CLAIM ACCRETION NUMBER  PACK   2   57   58   THE SEQUENCE NUMBER ASSIGNED TO THE CLAIM
                                                        RECORD WHEN ACCRETED (POSTED/PROCESSED) TO
                                                        THE BENEFICIARY MASTER RECORD AT THE CWF HOST
```

```
                                                SITE ON A GIVEN DATE.  THIS ELEMENT INDICATES
                                                THE POSITION OF THE CLAIM WITHIN THAT DAY'S
                                                PROCESSING AT THE CWF HOST. **(EXCEPTION: IF
                                                THE CLAIM RECORD IS MISSING THE ACCRETION DATE
                                                HCFA'S CWFMQA SYSTEM PLACES A ZERO IN THE
                                                ACCRETION NUMBER.

                                                3 DIGITS SIGNED

                                                DB2 ALIAS: CWF_CLM_ACRTN_NUM
                                                SAS ALIAS: ACRTN_NM
                                                STANDARD ALIAS: CWF_CLM_ACRTN_NUM
                                                TITLE ALIAS: ACCRETION_NUMBER

                                                SOURCE:
                                                CWF

     16. FI DOCUMENT CLAIM CONTROL   CHAR    23   59   81  UNIQUE CONTROL NUMBER ASSIGNED BY AN
         NUMBER                                            INTERMEDIARY TO AN INSTITUTIONAL CLAIM.

                                                COMMON ALIAS: ICN
                                                DB2 ALIAS: DOC_CLM_CNTL_NUM
                                                SAS ALIAS: CLM_CNTL
                                                STANDARD ALIAS: FI_DOC_CLM_CNTL_NUM
                                                TITLE ALIAS: ICN

                                                SOURCE:
                                                CWF

     17. FI ORIGINAL CLAIM CONTROL   CHAR    23   82  104  EFFECTIVE WITH VERSION G, THE ORIGINAL INTERMEDIARY
         NUMBER                                            CONTROL NUMBER (ICN) WHICH IS PRESENT ON ADJUSTMENT
                                                           CLAIMS, REPRESENTING THE ICN OF THE ORIGINAL
                                                           TRANSACTION NOW BEING ADJUSTED.

                                                COMMON ALIAS: ORIGINAL_ICN
                                                DB2 ALIAS: ORIG_CLM_CNTL_NUM
                                                SAS ALIAS: ORIGCNTL
                                                STANDARD ALIAS: FI_ORIG_CLM_CNTL_NUM
                                                TITLE ALIAS: ORIGINAL_ICN

                                                SOURCE:
  1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                              POSITIONS
```

```
              NAME              TYPE  LENGTH BEG   END                        CONTENTS
    ----------------------------  ----  ------ ---------  ------------------------------------------------
                                                         CWF

    18. CLAIM QUERY CODE          CHAR     1   105   105  CODE INDICATING THE TYPE OF CLAIM RECORD BEING PROCES
                                                         WITH RESPECT TO PAYMENT (DEBIT/CREDIT INDICATOR;
                                                         INTERIM/FINAL INDICATOR).

                                                         DB2 ALIAS: CLM_QUERY_CD
                                                         SAS ALIAS: QUERY_CD
                                                         STANDARD ALIAS: CLM_QUERY_CD
                                                         TITLE ALIAS: QUERY_CD

                                                         CODES:
                                                         0 = CREDIT ADJUSTMENT
                                                         1 = INTERIM BILL
                                                         2 = HOME HEALTH AGENCY (HHA) BENEFITS
                                                             EXHAUSTED (OBSOLETE 7/98)
                                                         3 = FINAL BILL
                                                         4 = DISCHARGE NOTICE (OBSOLETE 7/98)
                                                         5 = DEBIT ADJUSTMENT

                                                         SOURCE:
                                                         CWF

    19. PROVIDER NUMBER           CHAR     6   106   111  THE IDENTIFICATION NUMBER OF THE INSTITUTIONAL PROVID
                                                         CERTIFIED BY MEDICARE TO PROVIDE SERVICES TO THE
                                                         BENEFICIARY.

                                                         DB2 ALIAS: PRVDR_NUM
                                                         SAS ALIAS: PROVIDER
                                                         STANDARD ALIAS: PRVDR_NUM
                                                         TITLE ALIAS: PROVIDER_NUMBER

                                                         CODES:
                                                           REFER TO: PRVDR_NUM_TB
                                                                     IN THE CODES APPENDIX

                                                         SOURCE:
                                                         OSCAR

    20. NCH DAILY PROCESS DATE    NUM      8   112   119  EFFECTIVE WITH VERSION H, THE DATE THE CLAIM RECORD W.
                                                         PROCESSED BY HCFA'S CWFMQA SYSTEM (USED FOR INTERNAL
                                                         PURPOSES).
```

                                                    EFFECTIVE WITH VERSION I, THIS DATE IS USED IN CONJUN
                                                    WITH THE NCH SEGMENT LINK NUMBER TO KEEP CLAIMS WITH
                                                    MULTIPLE RECORDS/ SEGMENTS TOGETHER.

                                                    NOTE1:   WITH VERSION 'H' THIS FIELD WAS POP- ULATED W
                                                             DATA BEGINNING WITH NCH WEEKLY PROCESS DATE 1
                                                             UNDER VERSION 'I' CLAIMS PRIOR TO 10/3/97, TH.
                                                             BLANK UNDER VERSION 'H', WERE POPULATED WITH .

                                                    8 DIGITS UNSIGNED

                                                    DB2 ALIAS: NCH_DAILY_PROC_DT
                                                    SAS ALIAS: DAILY_DT
   1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
               NAME   TYPE LENGTH BEG END   CONTENTS
   ----------------------------   ---- ------ ---------   --
                                                    STANDARD ALIAS: NCH_DAILY_PROC_DT
                                                    TITLE ALIAS: DAILY_PROCESS_DT

                                                    EDIT-RULES:
                                                    YYYYMMDD

                                                    SOURCE:
                                                    NCH

     21. NCH SEGMENT LINK NUMBER   PACK   5   120 124   EFFECTIVE WITH VERSION 'I', THE SYSTEM GEN-
                                                    ERATED NUMBER USED IN CONJUNCTION WITH THE
                                                    NCH DAILY PROCESS DATE TO KEEP RECORDS/SEGMENTS
                                                    BELONGING TO A SPECIFIC CLAIM TOGETHER.
                                                    THIS FIELD WAS ADDED TO ENSURE THAT RECORDS/
                                                    SEGMENTS THAT COME IN ON THE SAME BATCH WITH
                                                    THE SAME IDENTIFYING INFORMATION IN THE LINK
                                                    GROUP ARE NOT MIXED WITH EACH OTHER.

                                                    NOTE: DURING THE VERSION I CONVERSION THIS
                                                            FIELD WAS POPULATED WITH DATA THROUGHOUT
                                                            HISTORY (BACK TO SERVICE YEAR 1991).

                                                    9 DIGITS SIGNED

                                                    DB2 ALIAS: NCH_SGMT_LINK_NUM

```
                                                SAS ALIAS: LINK_NUM
                                                STANDARD ALIAS: NCH_SGMT_LINK_NUM
                                                TITLE ALIAS: LINK_NUM

                                                SOURCE:
                                                NCH

  22. CLAIM TOTAL SEGMENT COUNT     NUM     2   125  126  EFFECTIVE WITH VERSION I, THE COUNT USED
                                                TO IDENTIFY THE TOTAL NUMBER OF SEGMENTS
                                                ASSOCIATED WITH A GIVEN CLAIM. EACH CLAIM
                                                COULD HAVE UP TO 10 SEGMENTS.

                                                NOTE:   DURING THE VERSION I CONVERSION, THIS
                                                        FIELD WAS POPULATED WITH DATA THROUGHOUT
                                                        HISTORY (BACK TO SERVICE YEAR 1991).
                                                        FOR INSTITUTIONAL CLAIMS, THE COUNT
                                                        FOR CLAIMS PRIOR TO 7/00 WILL BE 1 OR 2
                                                        (1 IF 45 OR LESS REVENUE CENTER LINES ON A
                                                        CLAIM AND 2 IF MORE THAN 45 REVENUE CENTER
                                                        LINES ON A CLAIM).  FOR NONINSTITUTIONAL
                                                        CLAIMS, THE COUNT WILL ALWAYS BE 1.

                                                2 DIGITS UNSIGNED

                                                DB2 ALIAS: TOT_SGMT_CNT
                                                SAS ALIAS: SGMT_CNT
                                                STANDARD ALIAS: CLM_TOT_SGMT_CNT
                                                TITLE ALIAS: SEGMENT_COUNT

                                                SOURCE:
                                                CWF
  1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
              NAME                 TYPE  LENGTH BEG   END                       CONTENTS
     ---------------------------- ----  ------ -------- -------------------------------------------------

  23. CLAIM SEGMENT NUMBER         NUM     2   127  128  EFFECTIVE WITH VERSION I, THE NUMBER USED
                                                TO IDENTIFY AN ACTUAL RECORD/SEGMENT (1 - 10)
                                                ASSOCIATED WITH A GIVEN CLAIM.

                                                NOTE:   DURING THE VERSION I CONVERSION THIS
                                                        FIELD WAS POPULATED WITH DATA THROUGHOUT
                                                        HISTORY (BACK TO SERVICE YEAR 1991).
```

                                              FOR INSTITUTIONAL CLAIMS PRIOR TO 7/00,
                                              THIS NUMBER WILL BE EITHER 1 OR 2. FOR
                                              NONINSTITUTIONAL CLAIMS, THE NUMBER WILL
                                              ALWAYS BE 1.

                                              2 DIGITS UNSIGNED

                                              DB2 ALIAS: CLM_SGMT_NUM
                                              SAS ALIAS: SGMT_NUM
                                              STANDARD ALIAS: CLM_SGMT_NUM
                                              TITLE ALIAS: SEGMENT_NUMBER

                                              SOURCE:
                                              CWF

24. CLAIM TOTAL LINE COUNT   NUM   3   129 131 EFFECTIVE WITH VERSION I, THE COUNT USED TO
                                              IDENTIFY THE TOTAL NUMBER OF REVENUE CENTER
                                              LINES ASSOCIATED WITH THE CLAIM.

                                              NOTE: DURING THE VERSION I CONVERSION THIS
                                                     FIELD WAS POPULATED WITH DATA THROUGHOUT
                                                     HISTORY (BACK TO SERVICE YEAR 1991).
                                                     PRIOR TO VERSION 'I', THE MAXIMUM LINE COUNT
                                                     WILL BE NO MORE THAN 58. EFFECTIVE WITH VERSI
                                                     'I', THE MAXIMUM LINE COUNT COULD BE 450.

                                              3 DIGITS UNSIGNED

                                              DB2 ALIAS: TOT_LINE_CNT
                                              SAS ALIAS: LINECNT
                                              STANDARD ALIAS: CLM_TOT_LINE_CNT
                                              TITLE ALIAS: TOTAL_LINE_COUNT

                                              SOURCE:
                                              CWF

25. CLAIM SEGMENT LINE COUNT   NUM   2   132 133 EFFECTIVE WITH VERSION I, THE COUNT USED
                                              TO IDENTIFY THE NUMBER OF REVENUE CENTER
                                              LINES ON A RECORD/SEGMENT.

                                              NOTE: DURING THE VERSION I CONVERSION THIS
                                                     FIELD WAS POPULATED WITH DATA THROUGHOUT
                                                     HISTORY (BACK TO SERVICE YEAR 1991).
                                                     THE MAXIMUM LINE COUNT PER RECORD/SEGMENT

```
                                         IS 45.

                                   2 DIGITS UNSIGNED

1                   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
               NAME                 TYPE  LENGTH BEG  END                       CONTENTS
     ---------------------------    ----  ------ ---------  --------------------------------------------------
                                                           DB2 ALIAS: SGMT_LINE_CNT
                                                           SAS ALIAS: SGMTLINE
                                                           STANDARD ALIAS: CLM_SGMT_LINE_CNT
                                                           TITLE ALIAS: SEGMENT_LINE_COUNT

                                                           SOURCE:
                                                           CWF

     ****  FI CLAIM COMMON GROUP    GROUP   359   134  492  INFORMATION COMMON TO FISCAL INTERMEDIARY (FI)
                                                           CLAIMS (INPATIENT/SNF, OUTPATIENT, HHA & HOSPICE),
                                                           FOR VERSION I OF NCH NEARLINE FILE.

                                                           STANDARD ALIAS: FI_CLM_CMN_GRP

     26. NCH PAYMENT AND EDIT RECORD CHAR    1    134  134  THE CODE USED FOR PAYMENT AND EDITING PURPOSES THAT
         IDENTIFICATION CODE                                INDICATES THE TYPE OF INSTITUTIONAL CLAIM RECORD.

                                                           DB2 ALIAS: PMT_EDIT_RIC_CD
                                                           SAS ALIAS: PE_RIC
                                                           STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD
                                                           TITLE ALIAS: NCH_PAYMENT_EDIT_RIC

                                                           CODES:
                                                           C = INPATIENT HOSPITAL, SNF
                                                           D = OUTPATIENT
                                                           E = RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS (EF
                                                               CHRISTIAN SCIENCE, PRIOR TO 7/00
                                                           F = HOME HEALTH AGENCY (HHA)
                                                           G = DISCHARGE NOTICE
                                                               (OBSOLETED 7/98)
                                                           I = HOSPICE

                                                           COMMENT:
                                                           PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                           PMT_EDIT_RIC_CD.
```

```
                                            SOURCE:
                                            NCH QA PROCESS

    27. CLAIM TRANSACTION CODE        CHAR     1   135 135   THE CODE DERIVED BY CWF TO INDICATE THE TYPE OF CLAIM
                                                             SUBMITTED BY AN INSTITUTIONAL PROVIDER.

                                            DB2 ALIAS: CLM_TRANS_CD
                                            SAS ALIAS: TRANS_CD
                                            STANDARD ALIAS: CLM_TRANS_CD
                                            SYSTEM ALIAS: LTCLTRAN
                                            TITLE ALIAS: TRANSACTION_CODE

                                            CODES:
                                               REFER TO: CLM_TRANS_TB
                                                         IN THE CODES APPENDIX

                                            SOURCE:
                                            CWF

    ****   CLAIM BILL TYPE GROUP       GROUP    2   136 137   EFFECTIVE WITH VERSION H, THE CLAIM FACILITY TYPE COD
 1                            FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                            POSITIONS
              NAME                    TYPE  LENGTH BEG   END                            CONTENTS
     ----------------------------    ----  ------ ---------  --------------------------------------------------
                                                             THE CLAIM SERVICE CLASSIFICATION TYPE CODE.  (THE FIR
                                                             POSITIONS OF THE ('TYPE OF BILL').  DURING THE VERSIO
                                                             CONVERSION, THIS GROUPING WAS CREATED THROUGHOUT HIST

                                            STANDARD ALIAS: CLM_BILL_TYPE_CD_GRP
                                            SYSTEM ALIAS: LTBILLCD

                                            CODES:
                                               REFER TO: CLM_BILL_TYPE_TB
                                                         IN THE CODES APPENDIX

    28. CLAIM FACILITY TYPE CODE      CHAR     1   136 136   THE FIRST DIGIT OF THE TYPE OF BILL (TOB1) SUBMITTED
                                                             INSTITUTIONAL CLAIM USED TO IDENTIFY THE TYPE OF FACI
                                                             THAT PROVIDED CARE TO THE BENEFICIARY.

                                            COMMON ALIAS: TOB1
                                            DB2 ALIAS: CLM_FAC_TYPE_CD
                                            SAS ALIAS: FAC_TYPE
```

```
                                        STANDARD ALIAS: CLM_FAC_TYPE_CD
                                        TITLE ALIAS: TOB1

                                        CODES:
                                          REFER TO: CLM_FAC_TYPE_TB
                                                    IN THE CODES APPENDIX

                                        SOURCE:
                                        CWF

29. CLAIM SERVICE               CHAR    1   137  137  THE SECOND DIGIT OF THE TYPE OF BILL (TOB2) SUBMITTED
    CLASSIFICATION TYPE CODE                         INSTITUTIONAL CLAIM RECORD TO INDICATE THE CLASSIFICA
                                                     THE TYPE OF SERVICE PROVIDED TO THE BENEFICIARY.

                                        COMMON ALIAS: TOB2
                                        DB2 ALIAS: SRVC_CLSFCTN_CD
                                        SAS ALIAS: TYPESRVC
                                        STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
                                        TITLE ALIAS: TOB2

                                        CODES:
                                          REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
                                                    IN THE CODES APPENDIX

                                        SOURCE:
                                        CWF

30. CLAIM FREQUENCY CODE        CHAR    1   138  138  THE THIRD DIGIT OF THE TYPE OF BILL (TOB3) SUBMITTED
                                                     INSTITUTIONAL CLAIM RECORD TO INDICATE THE SEQUENCE O
                                                     CLAIM IN THE BENEFICIARY'S CURRENT EPISODE OF CARE.

                                        COMMON ALIAS: TOB3
                                        DB2 ALIAS: CLM_FREQ_CD
                                        SAS ALIAS: FREQ_CD
                                        STANDARD ALIAS: CLM_FREQ_CD
                                        SYSTEM ALIAS: LTFREQ
                                        TITLE ALIAS: FREQUENCY_CD

 1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                               POSITIONS
            NAME                    TYPE   LENGTH BEG   END                          CONTENTS
   ------------------------------   ----   ------ --------   ----------------------------------------------------
                                        CODES:
```

```
                                         REFER TO: CLM_FREQ_TB
                                                   IN THE CODES APPENDIX

                                         SOURCE:
                                         CWF

31.  FILLER                  CHAR    1   139  139

32.  NCH MQA QUERY PATCH CODE  CHAR   1   140  140  EFFECTIVE WITH VERSION H, A CODE USED (FOR INTERNAL E
                                                    PURPOSES) TO INDICATE THAT THE CWFMQA PROCESS CHANGED
                                                    QUERY CODE SUBMITTED ON THE CLAIM RECORD.

                                         NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
                                                   FIELD WAS POPULATED WITH DATA.  CLAIMS PROCESS
                                                   PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS F

                                         DB2 ALIAS: MQA_QUERY_PATCH_CD
                                         SAS ALIAS: MQAQUERY
                                         STANDARD ALIAS: NCH_MQA_QUERY_PATCH_CD
                                         TITLE ALIAS: MQA_QUERY_PATCH_IND

                                         CODES:
                                         Y = MQA CHANGED BILL QUERY CODE ON A ACTION
                                             CODE 6 (FORCE ACTION CODE 2)
                                             BILL TO A ZERO. (EFF. 10/12/93)
                                         Z = MQA CHANGED BILL QUERY CODE ON A ACTION
                                             CODE 4 (CANCEL ONLY ADJUSTMENT)
                                             BILL TO ZERO.  (EFF. 5/16/94)

                                         SOURCE:
                                         NCH QA PROCESS

33.  CLAIM DISPOSITION CODE   CHAR    2   141  142  CODE INDICATING THE DISPOSITION OR OUTCOME OF THE PRO
                                                    OF THE CLAIM RECORD.

                                         DB2 ALIAS: CLM_DISP_CD
                                         SAS ALIAS: DISP_CD
                                         STANDARD ALIAS: CLM_DISP_CD
                                         TITLE ALIAS: DISPOSITION_CD

                                         CODES:
                                           REFER TO: CLM_DISP_TB
                                                     IN THE CODES APPENDIX
```

```
                                                SOURCE:
                                                CWF

    34. NCH EDIT DISPOSITION CODE    CHAR    2   143  144  EFFECTIVE WITH VERSION H, A CODE USED (FOR INTERNAL E
                                                           PURPOSES) TO INDICATE THE DISPOSITION OF THE CLAIM AF
                                                           EDITING IN THE CWFMQA PROCESS.

                                                NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
                                                       FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSE
                                                       TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                POSITIONS
                NAME                   TYPE  LENGTH BEG  END                           CONTENTS
        -----------------------------  ----  ------ ---------  -------------------------------------------------
                                                           DB2 ALIAS: NCH_EDIT_DISP_CD
                                                           SAS ALIAS: EDITDISP
                                                           STANDARD ALIAS: NCH_EDIT_DISP_CD
                                                           TITLE ALIAS: NCH_EDIT_DISP

                                                           CODES:
                                                           00 = NO MQA ERRORS
                                                           10 = POSSIBLE DUPLICATE
                                                           20 = UTILIZATION ERROR
                                                           30 = CONSISTENCY ERROR
                                                           40 = ENTITLEMENT ERROR
                                                           50 = IDENTIFICATION ERROR
                                                           60 = LOGICAL DUPLICATE
                                                           70 = SYSTEMS DUPLICATE

                                                           SOURCE:
                                                           NCH QA PROCESS

    35. NCH CLAIM BIC MODIFY H CODE   CHAR    1   145  145  EFFECTIVE WITH VERSION H, THE CODE USED (FOR INTERNAL
                                                            EDITING PURPOSES) TO IDENTIFY A CLAIM RECORD THAT WAS
                                                            SUBMITTED WITH AN INCORRECT HA, HB, OR HC BIC.

                                                 NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
                                                        FIELD WAS POPULATED WITH DATA.   CLAIMS PROCES
                                                        PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS F

                                                 DB2 ALIAS: NCH_BIC_MDFY_CD
                                                 SAS ALIAS: BIC_MDFY
```

```
                                              STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD
                                              TITLE ALIAS: BIC_MODIFY_CD


                                              CODES:
                                              H = BIC SUBMITTED BY CWF = HA, HB OR HC
                                              BLANK = NO HA, HB OR HC BIC PRESENT


                                              SOURCE:
                                              NCH QA PROCESS

  36. BENEFICIARY RESIDENCE SSA    CHAR    3   146  148  THE SSA STANDARD COUNTY CODE OF A BENEFICIARY'S RESID
      STANDARD COUNTY CODE

                                              DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
                                              DB2 ALIAS: BENE_SSA_CNTY_CD
                                              SAS ALIAS: CNTY_CD
                                              STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
                                              TITLE ALIAS: BENE_COUNTY_CD


                                              EDIT-RULES:
                                              OPTIONAL: MAY BE BLANK


                                              SOURCE:
                                              SSA/EDB

  37. FI CLAIM RECEIPT DATE         NUM    8   149  156  THE DATE THE FISCAL INTERMEDIARY RECEIVED THE
                                                         INSTITUTIONAL CLAIM FROM THE PROVIDER.


                                              8 DIGITS UNSIGNED
1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                      POSITIONS
                NAME              TYPE  LENGTH BEG  END                         CONTENTS
      ---------------------------- ---- ------ --------  -------------------------------------------------


                                              DB2 ALIAS: FI_CLM_RCPT_DT
                                              SAS ALIAS: RCPT_DT
                                              STANDARD ALIAS: FI_CLM_RCPT_DT
                                              TITLE ALIAS: RECEIPT_DT


                                              EDIT-RULES:
                                              YYYYMMDD


                                              COMMENT:
                                              PRIOR TO VERSION H THIS FIELD WAS NAMED:
```

FICARR_CLM_RCPT_DT.

SOURCE:
CWF

38. FI CLAIM SCHEDULED PAYMENT   NUM   8   157 164   THE SCHEDULED DATE OF PAYMENT TO THE INSTITU-
    DATE   TIONAL PROVIDER, AS REFLECTED ON THE CLAIM
                                                          RECORD TRANSMITTED TO THE CWF HOST. NOTE:
                                                          THIS DATE IS CONSIDERED TO BE THE DATE PAID
                                                          SINCE NO ADDITIONAL INFORMATION AS TO THE
                                                          ACTUAL PAYMENT DATE IS AVAILABLE.

                                                          8 DIGITS UNSIGNED

                                                          DB2 ALIAS: FI_SCHLD_PMT_DT
                                                          SAS ALIAS: SCHLD_DT
                                                          STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT
                                                          TITLE ALIAS: SCHEDULED_PMT_DT

                                                          EDIT-RULES:
                                                          YYYYMMDD

                                                          COMMENT:
                                                          PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                          FICARR_CLM_PMT_DT.

                                                          SOURCE:
                                                          CWF

39. CWF FORWARDED DATE   NUM   8   165 172   EFFECTIVE WITH VERSION H, THE DATE CWF FORWARDED THE
                                                          RECORD TO HCFA (USED FOR INTERNAL EDITING PURPOSES).

                                                          NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
                                                                 FIELD WAS POPULATED WITH DATA. CLAIMS PROCESS
                                                                 PRIOR TO 10/3/97 WILL CONTAIN ZEROES IN THIS F

                                                          8 DIGITS UNSIGNED

                                                          DB2 ALIAS: CWF_FRWRD_DT
                                                          SAS ALIAS: FRWRD_DT
                                                          STANDARD ALIAS: CWF_FRWRD_DT
                                                          TITLE ALIAS: FORWARD_DT

                                                          EDIT-RULES:

```
                                         YYYYMMDD
1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
            NAME                  TYPE  LENGTH BEG  END                           CONTENTS
    --------------------------    ----  ------ ---------  --------------------------------------------------
                                                          SOURCE:
                                                          CWF

    40. FI NUMBER                 CHAR     5   173  177   THE IDENTIFICATION NUMBER ASSIGNED BY HCFA TO A FISCA
                                                          INTERMEDIARY AUTHORIZED TO PROCESS INSTITUTIONAL CLAI
                                                          RECORDS.

                                                          DB2 ALIAS: FI_NUM
                                                          SAS ALIAS: FI_NUM
                                                          STANDARD ALIAS: FI_NUM
                                                          SYSTEM ALIAS: LTFI
                                                          TITLE ALIAS: INTERMEDIARY

                                                          CODES:
                                                            REFER TO: FI_NUM_TB
                                                                       IN THE CODES APPENDIX

                                                          COMMENT:
                                                          PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                          FICARR_IDENT_NUM.

                                                          SOURCE:
                                                          CWF

    41. CWF CLAIM ASSIGNED NUMBER CHAR     8   178  185   EFFECTIVE WITH VERSION H, THE NUMBER ASSIGNED
                                                          TO AN INSTITUTIONAL CLAIM RECORD BY CWF (USED
                                                          FOR INTERNAL EDITING PURPOSES).

                                                          NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                                 10/3/97 THIS FIELD WAS POPULATED WITH
                                                                 DATA.  CLAIMS PROCESSED PRIOR TO 10/3/97
                                                                 WILL CONTAIN SPACES IN THIS FIELD.

                                                          DB2 ALIAS: CWF_CLM_ASGN_NUM
                                                          SAS ALIAS: ASGN_NUM
                                                          STANDARD ALIAS: CWF_CLM_ASGN_NUM
                                                          TITLE ALIAS: ASSIGNED_NUM
```

```
                                                          SOURCE:
                                                          CWF

    42. CWF TRANSMISSION BATCH      CHAR    4   186 189   EFFECTIVE WITH VERSION H, THE NUMBER ASSIGNED
        NUMBER                                            TO EACH BATCH OF CLAIMS TRANSACTIONS SENT FROM
                                                          CWF(USED FOR INTERNAL EDITING PURPOSES).

                                                          NOTE:   BEGINNING 11/98, THIS FIELD WILL BE
                                                                  POPULATED WITH DATA.  CLAIMS PROCESSED
                                                                  PRIOR TO 11/98 WILL CONTAIN SPACES IN
                                                                  THIS FIELD.

                                                          DB2 ALIAS: TRNSMSN_BATCH_NUM
                                                          SAS ALIAS: FIBATCH
                                                          STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM
                                                          TITLE ALIAS: BATCH_NUM
```

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

```
                                            POSITIONS
             NAME                 TYPE  LENGTH BEG   END                         CONTENTS
    ---------------------------   ----  ------ ---------   ------------------------------------------------
                                                          SOURCE:
                                                          CWF

    43. BENEFICIARY MAILING CONTACT CHAR   9   190 198   THE ZIP CODE OF THE MAILING ADDRESS WHERE THE
        ZIP CODE                                          BENEFICIARY MAY BE CONTACTED.

                                                          DB2 ALIAS: BENE_MLG_ZIP_CD
                                                          SAS ALIAS: BENE_ZIP
                                                          STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD
                                                          TITLE ALIAS: BENE_ZIP

                                                          SOURCE:
                                                          EDB

    44. BENEFICIARY SEX            CHAR    1   199 199   THE SEX OF A BENEFICIARY.
        IDENTIFICATION CODE
                                                          COMMON ALIAS: SEX_CD
                                                          DA3 ALIAS: SEX_CODE
                                                          DB2 ALIAS: BENE_SEX_IDENT_CD
                                                          SAS ALIAS: SEX
                                                          STANDARD ALIAS: BENE_SEX_IDENT_CD
```

```
                                               SYSTEM ALIAS: LTSEX
                                               TITLE ALIAS: SEX_CD

                                               EDIT-RULES:
                                               REQUIRED FIELD

                                               CODES:
                                               1 = MALE
                                               2 = FEMALE
                                               0 = UNKNOWN

                                               SOURCE:
                                               SSA,RRB,EDB

    45. BENEFICIARY RACE CODE         CHAR    1   200  200  THE RACE OF A BENEFICIARY.

                                               DA3 ALIAS: RACE_CODE
                                               DB2 ALIAS: BENE_RACE_CD
                                               SAS ALIAS: RACE
                                               STANDARD ALIAS: BENE_RACE_CD
                                               SYSTEM ALIAS: LTRACE
                                               TITLE ALIAS: RACE_CD

                                               CODES:
                                               0 = UNKNOWN
                                               1 = WHITE
                                               2 = BLACK
                                               3 = OTHER
                                               4 = ASIAN
                                               5 = HISPANIC
                                               6 = NORTH AMERICAN NATIVE

                                               SOURCE:
                                               SSA
```

```
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
            NAME                  TYPE   LENGTH BEG   END                             CONTENTS
    ---------------------------   ----   ------ --------   --------------------------------------------------
    46. BENEFICIARY BIRTH DATE    NUM       8   201   208  THE BENEFICIARY'S DATE OF BIRTH.

                                               8 DIGITS UNSIGNED
```

```
                                        DB2 ALIAS: BENE_BIRTH_DT
                                        SAS ALIAS: BENE_DOB
                                        STANDARD ALIAS: BENE_BIRTH_DT
                                        TITLE ALIAS: BENE_BIRTH_DATE

                                        EDIT-RULES:
                                        YYYYMMDD

                                        SOURCE:
                                        CWF

47. CWF BENEFICIARY MEDICARE    CHAR    2   209 210  THE CWF-DERIVED REASON FOR A BENEFICIARY'S
    STATUS CODE                                      ENTITLEMENT TO MEDICARE BENEFITS, AS OF THE
                                                     REFERENCE DATE (CLM_THRU_DT).

                                        COBOL ALIAS: MSC
                                        COMMON ALIAS: MSC
                                        DB2 ALIAS: BENE_MDCR_STUS_CD
                                        SAS ALIAS: MS_CD
                                        STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
                                        SYSTEM ALIAS: LTMSC
                                        TITLE ALIAS: MSC

                                        DERIVATION:
                                        CWF DERIVES MSC FROM THE FOLLOWING:
                                            1.  DATE OF BIRTH
                                            2.  CLAIM THROUGH DATE
                                            3.  ORIGINAL/CURRENT REASONS FOR ENTITLEMENT
                                            4.  ESRD INDICATOR
                                            5.  BENEFICIARY CLAIM NUMBER
                                        ITEMS 1,3,4,5 COME FROM THE CWF BENEFICIARY
                                        MASTER RECORD; ITEM 2 COMES FROM THE FI/CARRIER
                                        CLAIM RECORD.  MSC IS ASSIGNED AS FOLLOWS:
```

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 AND OVER	N/A
11	YES	N/A	YES	65 AND OVER	N/A
20	NO	YES	NO	UNDER 65	N/A
21	NO	YES	YES	UNDER 65	N/A
31	NO	NO	YES	ANY AGE	T.

```
                                        CODES:
                                        10 = AGED WITHOUT ESRD
```

```
                                                    11 = AGED WITH ESRD
                                                    20 = DISABLED WITHOUT ESRD
                                                    21 = DISABLED WITH ESRD
                                                    31 = ESRD ONLY

                                                    COMMENT:
                                                    PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                    BENE_MDCR_STUS_CD.  THE NAME HAS BEEN CHANGED
1                       FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
            NAME                    TYPE  LENGTH BEG   END                         CONTENTS
    ---------------------------     ----  ------ ---------    -------------------------------------------------------
                                                    TO DISTINGUISH THIS CWF-DERIVED FIELD FROM THE
                                                    EDB-DERIVED MSC (BENE_MDCR_STUS_CD).

                                                    SOURCE:
                                                    CWF

    48. CLAIM PATIENT 6 POSITION    CHAR     6   211  216    THE FIRST 6 POSITIONS OF THE MEDICARE PATIENT'S
        SURNAME                                              SURNAME (LAST NAME) AS REPORTED BY THE PROVIDER
                                                             ON THE CLAIM.

                                                             NOTE1: PRIOR TO VERSION H, THIS FIELD WAS ONLY
                                                                    PRESENT ON THE IP/SNF CLAIM RECORD.
                                                                    EFFECTIVE WITH VERSION H, THIS FIELD IS
                                                                    PRESENT ON ALL CLAIM TYPES.

                                                             NOTE2: FOR OP, HHA, HOSPICE AND ALL CARRIER
                                                                    CLAIMS, DATA WAS POPULATED BEGINNING
                                                                    WITH NCH WEEKLY PROCESS 10/3/97.  CLAIMS
                                                                    PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                                    SPACES IN THIS FIELD.

                                                             COMMON ALIAS: PATIENT_SURNAME
                                                             DB2 ALIAS: PTNT_6_PSTN_SRNM
                                                             SAS ALIAS: SURNAME
                                                             STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME
                                                             TITLE ALIAS: PATIENT_SURNAME

                                                             SOURCE:
                                                             CWF

    49. CLAIM PATIENT 1ST INITIAL   CHAR     1   217  217    THE FIRST INITIAL OF THE MEDICARE PATIENT'S
```

```
          GIVEN NAME                                            GIVEN NAME (FIRST NAME) AS REPORTED BY THE
                                                                PROVIDER ON THE CLAIM.

                                                                NOTE1: PRIOR TO VERSION H, THIS FIELD WAS ONLY
                                                                       PRESENT ON THE IP/SNF CLAIM RECORD.
                                                                       EFFECTIVE WITH VERSION H, THIS FIELD
                                                                       IS PRESENT ON ALL CLAIM TYPES.

                                                                NOTE2: FOR OP, HHA, HOSPICE AND ALL CARRIER CLAIMS,
                                                                       DATA WAS POPULATED BEGINNING WITH NCH
                                                                       WEEKLY PROCESS DATE 10/3/97.  CLAIMS
                                                                       PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                                       SPACES IN THIS FIELD.

                                                                COMMON ALIAS: PATIENT_GIVEN_NAME
                                                                DB2 ALIAS: 1ST_INITL_GVN_NAME
                                                                SAS ALIAS: FRSTINIT
                                                                STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
                                                                TITLE ALIAS: PATIENT_FIRST_INITIAL

                                                                SOURCE:
                                                                CWF

   50. CLAIM PATIENT FIRST INITIAL  CHAR      1   218  218  THE FIRST INITIAL OF THE MEDICARE PATIENT'S
       MIDDLE NAME                                          MIDDLE NAME AS REPORTED BY THE PROVIDER ON
1                              FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                    POSITIONS
                    NAME                TYPE  LENGTH BEG  END                         CONTENTS
       ---------------------------- ---- ------ --------- -------------------------------------------------
                                                                THE CLAIM.

                                                                NOTE1:  PRIOR TO VERSION H, THIS FIELD WAS ONLY
                                                                        PRESENT ON THE IP/SNF CLAIM RECORD.
                                                                        EFFECTIVE WITH VERSION H, THIS FIELD IS
                                                                        PRESENT ON ALL CLAIM TYPES.

                                                                NOTE2:  FOR OP, HHA, HOSPICE AND ALL CARRIER CLAIMS,
                                                                        DATA WAS POPULATED BEGINNING WITH NCH
                                                                        WEEKLY PROCESS DATE 10/3/97.   CLAIMS PRO-
                                                                        CESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                                        SPACES IN THIS FIELD.

                                                                COMMON ALIAS: PATIENT_MIDDLE_NAME
```

```
                                        DB2 ALIAS: 1ST_INITL_MDL_NAME
                                        SAS ALIAS: MDL_INIT
                                        STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME
                                        TITLE ALIAS: PATIENT_MIDDLE_INITIAL

                                        SOURCE:
                                        CWF
```

51. BENEFICIARY CWF LOCATION   CHAR   1   219 219   THE CODE THAT IDENTIFIES THE COMMON WORKING FILE
    CODE   (CWF) LOCATION (THE HOST SITE) WHERE A BENEFICIARY'S
                                                      MEDICARE UTILIZATION RECORDS ARE MAINTAINED.

```
                                        COMMON ALIAS: CWF_HOST
                                        DB2 ALIAS: BENE_CWF_LOC_CD
                                        SAS ALIAS: CWFLOCCD
                                        STANDARD ALIAS: BENE_CWF_LOC_CD
                                        SYSTEM ALIAS: LTCWFLOC
                                        TITLE ALIAS: CWF_HOST

                                        CODES:
                                        B = MID-ATLANTIC
                                        C = SOUTHWEST
                                        D = NORTHEAST
                                        E = GREAT LAKES
                                        F = GREAT WESTERN
                                        G = KEYSTONE
                                        H = SOUTHEAST
                                        I = SOUTH
                                        J = PACIFIC

                                        SOURCE:
                                        CWF
```

52. CLAIM PRINCIPAL DIAGNOSIS   CHAR   5   220 224   THE ICD-9-CM DIAGNOSIS CODE IDENTIFYING THE DIAGNOSIS
    CODE   CONDITION, PROBLEM OR OTHER REASON FOR THE
                                                      ADMISSION/ENCOUNTER/VISIT SHOWN IN THE MEDICAL RECORD
                                                      CHIEFLY RESPONSIBLE FOR THE SERVICES PROVIDED.

```
                                        NOTE:  EFFECTIVE WITH VERSION H, THIS DATA IS ALSO
                                        REDUNDANTLY STORED AS THE FIRST OCCURRENCE OF THE DIA
                                        TRAILER.
```

   1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

```
                                          POSITIONS
                  NAME                TYPE  LENGTH BEG   END                          CONTENTS
     ----------------------------     ----  ------ ---------   -------------------------------------------------
                                                              DB2 ALIAS: PRNCPAL_DGNS_CD
                                                              SAS ALIAS: PDGNS_CD
                                                              STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
                                                              TITLE ALIAS: PRINCIPAL_DIAGNOSIS

                                                              EDIT-RULES:
                                                              ICD-9-CM

                                                              SOURCE:
                                                              CWF

     53. FILLER                       CHAR    1    225   225

     54. CLAIM MEDICARE NON PAYMENT   CHAR    1    226   226   THE REASON THAT NO MEDICARE PAYMENT IS MADE FOR
         REASON CODE                                           SERVICES ON AN INSTITUTIONAL CLAIM.

                                                              NOTE:  EFFECTIVE WITH VERSION I, THIS FIELD WAS
                                                                     PUT ON ALL INSTITUTIONAL CLAIM TYPES.
                                                                     PRIOR TO VERSION I, THIS FIELD WAS PRESENT
                                                                     ONLY ON INPATIENT/SNF CLAIMS.

                                                              DB2 ALIAS: MDCR_NPMT_RSN_CD
                                                              SAS ALIAS: NOPAY_CD
                                                              STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
                                                              SYSTEM ALIAS: LTNPMT
                                                              TITLE ALIAS: NON_PAYMENT_REASON

                                                              EDIT-RULES:
                                                              OPTIONAL

                                                              CODES:
                                                                REFER TO: CLM_MDCR_NPMT_RSN_TB
                                                                          IN THE CODES APPENDIX

                                                              SOURCE:
                                                              CWF

     55. CLAIM EXCEPTED/NONEXCEPTED   CHAR    1    227   227   EFFECTIVE WITH VERSION I, THE CODE USED TO IDENTIFY
         MEDICAL TREATMENT CODE                               WHETHER OR NOT THE MEDICAL CARE OR TREATMENT RECEIVED
                                                              BY A BENEFICIARY, WHO HAS ELECTED CARE FROM A
                                                              RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (RNHCI),
```

```
                                            IS EXCEPTED OR NONEXCEPTED.  EXCEPTED IS MEDICAL CARE
                                            OR TREATMENT THAT IS RECEIVED INVOLUNTARILY OR IS RE-
                                            QUIRED UNDER FEDERAL, STATE OR LOCAL LAW. NONEXCEPTED
                                            DEFINED AS MEDICAL CARE OR TREATMENT OTHER THAN EXCEP

                                            DB2 ALIAS: EXCPTD_NEXCPTD_CD
                                            SAS ALIAS: TRTMT_CD
                                            STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
                                            TITLE ALIAS: EXCPTD_NEXCPTD_CD

                                            CODES:
                                            0 = NO ENTRY
                                            1 = EXCEPTED
                                            2 = NONEXCEPTED
```

```
  1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
           NAME                 TYPE  LENGTH BEG  END                           CONTENTS
   ---------------------------- ----  ------ --------  ----------------------------------------------------
                                            SOURCE:
                                            CWF

  56. CLAIM PAYMENT AMOUNT      PACK     6   228  233  AMOUNT OF PAYMENT MADE FROM THE MEDICARE TRUST FUND F
                                            SERVICES COVERED BY THE CLAIM RECORD.  GENERALLY, THE
                                            IS CALCULATED BY THE FI OR CARRIER; AND REPRESENTS WH
                                            PAID TO THE INSTITUTIONAL PROVIDER, PHYSICIAN, OR SUP
                                            WITH THE EXCEPTIONS NOTED BELOW.  **NOTE:  IN SOME
                                            SITUATIONS, A NEGATIVE CLAIM PAYMENT AMOUNT MAY BE PR
                                            SENT; E.G., (1) WHEN A BENEFICIARY IS CHARGED THE FUL
                                            DEDUCTIBLE DURING A SHORT STAY AND THE DEDUCTIBLE EXC
                                            THE AMOUNT MEDICARE PAYS; OR (2) WHEN A BENEFICIARY I
                                            CHARGED A COINSURANCE AMOUNT DURING A LONG STAY AND T
                                            COINSURANCE AMOUNT EXCEEDS THE AMOUNT MEDICARE PAYS (
                                            PREVALENT SITUATION INVOLVES PSYCH HOSPITALS WHO ARE
                                            DAILY PER DIEM RATE NO MATTER WHAT THE CHARGES ARE.)

                                            UNDER IP PPS, INPATIENT HOSPITAL SERVICES ARE PAID BA
                                            A PREDETERMINED RATE PER DISCHARGE, USING THE DRG PAT
                                            CLASSIFICATION SYSTEM AND THE PRICER PROGRAM.   ON TH
                                            PPS CLAIM, THE PAYMENT AMOUNT INCLUDES THE DRG OUTLIE
                                            APPROVED PAYMENT AMOUNT, DISPROPORTIONATE SHARE (SINC
                                            5/1/86), INDIRECT MEDICAL EDUCATION (SINCE 10/1/88),
                                            PPS CAPITAL (SINCE 10/1/91).  IT DOES NOT INCLUDE THE
```

THRU AMOUNTS (I.E., CAPITAL-RELATED COSTS, DIRECT MED
EDUCATION COSTS, KIDNEY ACQUISITION COSTS, BAD DEBTS)
ANY BENEFICIARY-PAID AMOUNTS (I.E., DEDUCTIBLES AND
COINSURANCE); OR ANY OTHER PAYER REIMBURSEMENT.

UNDER SNF PPS, SNFS WILL CLASSIFY BENEFICIARIES USING
PATIENT CLASSIFICATION SYSTEM KNOWN AS RUGS III. FOR
SNF PPS CLAIM, THE SNF PRICER WILL CALCULATE/RETURN T
FOR EACH REVENUE CENTER LINE ITEM WITH REVENUE CENTER
'0022'; MULTIPLY THE RATE TIMES THE UNITS COUNT; AND
SUM THE AMOUNT PAYABLE FOR ALL LINES WITH REVENUE CEN
CODE '0022' TO DETERMINE THE TOTAL CLAIM PAYMENT AMOU

UNDER OUTPATIENT PPS, THE NATIONAL AMBULATORY PAYMENT
CLASSIFICATION (APC) RATE THAT IS CALCULATED FOR EACH
GROUP IS THE BASIS FOR DETERMINING THE TOTAL PAYMENT.
MEDICARE PAYMENT AMOUNT TAKES INTO ACCOUNT THE WAGE I
ADJUSTMENT AND THE BENEFICIARY DEDUCTIBLE AND COINSUR
AMOUNTS. NOTE: THERE IS NO CWF EDIT CHECK TO VALIDAT
THE REVENUE CENTER MEDICARE PAYMENT AMOUNT EQUALS THE
LEVEL MEDICARE PAYMENT AMOUNT.

UNDER HOME HEALTH PPS, BENEFICIARIES WILL BE CLASSIFI
AN APPROPRIATE CASE MIX CATEGORY KNOWN AS THE HOME HE
RESOURCE GROUP. A HIPPS CODE IS THEN GENERATED
CORRESPONDING TO THE CASE MIX CATEGORY (HHRG).

FOR THE RAP, THE PRICER WILL DETERMINE THE PAYMENT AM
APPROPRIATE TO THE HIPPS CODE BY COMPUTING 60% (FOR F
EPISODE) OR 50% (FOR SUBSEQUENT EPISODES) OF THE CASE
EPISODE PAYMENT. THE PAYMENT IS THEN WAGE INDEX ADJU

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

```
                                        POSITIONS
          NAME                   TYPE  LENGTH BEG  END                        CONTENTS
------------------------------   ----  ------ ---------  ----------------------------------------------------
                                                          FOR THE FINAL CLAIM, PRICER CALCULATES 100% OF THE AM
                                                          DUE, BECAUSE THE FINAL CLAIM IS PROCESSED AS AN ADJUS
                                                          TO THE RAP, REVERSING THE RAP PAYMENT IN FULL.  ALTHO
                                                          FINAL CLAIM WILL SHOW 100% PAYMENT AMOUNT, THE PROVID
                                                          ACTUALLY RECEIVE THE 40% OR 50% PAYMENT.

                                                          EXCEPTIONS:  FOR CLAIMS INVOLVING DEMOS AND BBA ENCOU
```

DATA, THE AMOUNT REPORTED IN THIS FIELD MAY NOT JUST
REPRESENT THE ACTUAL PROVIDER PAYMENT.

    FOR DEMO IDS '01','02','03','04' -- CLAIMS CONTA
    AMOUNT PAID TO THE PROVIDER, EXCEPT THAT SPECIAL
    'DIFFERENTIALS' PAID OUTSIDE THE NORMAL PAYMENT
    ARE NOT INCLUDED.

    FOR DEMO IDS '05','15' -- ENCOUNTER DATA 'CLAIMS
    CONTAIN AMOUNT MEDICARE WOULD HAVE PAID UNDER FF
    INSTEAD OF THE ACTUAL PAYMENT TO THE MCO.

    FOR DEMO IDS '06','07','08' -- CLAIMS CONTAIN AC
    PROVIDER PAYMENT BUT REPRESENT A SPECIAL NEGOTIA
    BUNDLED PAYMENT FOR BOTH PART A AND PART B SERVI
    TO IDENTIFY WHAT THE CONVENTIONAL PROVIDER PART
    PAYMENT WOULD HAVE BEEN, CHECK VALUE CODE = 'Y4'
    RELATED NONINSTITUTIONAL (PHYSICIAN/SUPPLIER) CL
    CONTAIN WHAT WOULD HAVE BEEN PAID HAD THERE BEEN
    DEMO.

    FOR BBA ENCOUNTER DATA (NON-DEMO) -- 'CLAIMS' CO
    AMOUNT MEDICARE WOULD HAVE PAID UNDER FFS, INSTE
    THE ACTUAL PAYMENT TO THE BBA PLAN.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS S9(7)V9
THE NONINSTITUTIONAL CLAIM RECORDS CARRIED THIS FIELD
ITEM. EFFECTIVE WITH VERSION H, THIS ELEMENT IS A CL
FIELD ACROSS ALL CLAIM TYPES (AND THE LINE ITEM FIELD
RENAMED.)

```
                                                SOURCE:
                                                CWF

                                                LIMITATIONS:
                                                PRIOR TO 4/6/93, ON INPATIENT, OUTPATIENT, AND
1                       FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                       POSITIONS
           NAME                TYPE  LENGTH BEG   END                         CONTENTS
------------------------------ ----  ------ --------- --------------------------------------------------
                                                PHYSICIAN/SUPPLIER CLAIMS CONTAINING A
                                                CLM_DISP_CD OF '02', THE AMOUNT SHOWN AS THE MEDICARE
                                                REIMBURSEMENT DOES NOT TAKE INTO CONSIDERATION
                                                ANY CWF AUTOMATIC ADJUSTMENTS (INVOLVING ERRONEOUS
                                                DEDUCTIBLES IN MOST CASES).  IN AS MANY AS 30% OF
                                                THE CLAIMS (30% IP, 15% OP, 5% PART B), THE
                                                REIMBURSEMENT REPORTED ON THE CLAIMS MAY BE OVER
                                                OR UNDER THE ACTUAL MEDICARE PAYMENT AMOUNT.

    57. NCH PRIMARY PAYER CLAIM    PACK     6   234  239  THE AMOUNT OF A PAYMENT MADE ON BEHALF OF A MEDICARE
        PAID AMOUNT                                       BENEFICIARY BY A PRIMARY PAYER OTHER THAN MEDICARE, T
                                                          PROVIDER IS APPLYING TO COVERED MEDICARE CHARGES ON A
                                                          INSTITUTIONAL, CARRIER, OR DMERC CLAIM.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: PRMRY_PYR_PD_AMT
                                                          SAS ALIAS: PRPAYAMT
                                                          STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
                                                          TITLE ALIAS: PRIMARY_PAYER_AMOUNT

                                                          EDIT-RULES:
                                                          $$$$$$$$$CC

                                                          COMMENT:
                                                          PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                          BENE_PRMRY_PYR_CLM_PMT_AMT AND THE FIELD SIZE
                                                          WAS S9(7)V99.

                                                          SOURCE:
                                                          NCH

    58. NCH PRIMARY PAYER CODE    CHAR     1   240  240  THE CODE, ON AN INSTITUTIONAL CLAIM, SPECIFYING A FED
                                                          NON-MEDICARE PROGRAM OR OTHER SOURCE THAT HAS PRIMARY
```

```
                                            RESPONSIBILITY FOR THE PAYMENT OF THE MEDICARE BENEFI
                                            HEALTH INSURANCE BILLS.


                                            DB2 ALIAS: NCH_PRMRY_PYR_CD
                                            SAS ALIAS: PRPAY_CD
                                            STANDARD ALIAS: NCH_PRMRY_PYR_CD
                                            TITLE ALIAS: PRIMARY_PAYER_CD


                                            DERIVATION:
                                            DERIVED FROM:
                                              CLM_VAL_CD
                                              CLM_VAL_AMT


                                            DERIVATION RULES

                                              SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
                                              CLM_VAL_CD = '12'

                                              SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
                                              CLM_VAL_CD = '13'

                                              SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
   1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                            POSITIONS
            NAME                    TYPE  LENGTH BEG  END                              CONTENTS
   ---------------------------- ---- ------ --------  --------------------------------------------------
                                            CLM_VAL_CD = '16' AND CLM_VAL_AMT IS ZEROES

                                              SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE
                                              CLM_VAL_CD = '14'

                                              SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE
                                              CLM_VAL_CD = '15'

                                              SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE
                                              CLM_VAL_CD = '16' (CLM_VAL_AMT NOT
                                              EQUAL TO ZEROES)

                                              SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE
                                              CLM_VAL_CD = '43'

                                              SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE
                                              CLM_VAL_CD = '41'
```

```
                                            SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE
                                            CLM_VAL_CD = '42'

                                            SET NCH_PRMRY_PYR_CD TO 'L' (OR PRIOR TO 4/97
                                            SET CODE TO 'J') WHERE THE CLM_VAL_CD = '47'

                                            CODES:
                                              REFER TO: BENE_PRMRY_PYR_TB
                                                          IN THE CODES APPENDIX

                                            COMMENT:
                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                            BENE_PRMRY_PYR_CD.

                                            SOURCE:
                                            NCH

    59. FI REQUESTED CLAIM CANCEL     CHAR     1   241  241  THE REASON THAT AN INTERMEDIARY REQUESTED CANCELLING
        REASON CODE                                          A PREVIOUSLY SUBMITTED INSTITUTIONAL CLAIM.

                                            DB2 ALIAS: RQST_CNCL_RSN_CD
                                            SAS ALIAS: CANCELCD
                                            STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
                                            TITLE ALIAS: CANCEL_CD

                                            CODES:
                                              REFER TO: FI_RQST_CLM_CNCL_RSN_TB
                                                          IN THE CODES APPENDIX

                                            COMMENT:
                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                            INTRMDRY_RQST_CLM_CNCL_RSN_CD.

                                            SOURCE:
                                            CWF

    60. FI CLAIM ACTION CODE          CHAR     1   242  242  THE TYPE OF ACTION REQUESTED BY THE INTERMEDIARY
                                                             TO BE TAKEN ON AN INSTITUTIONAL CLAIM.
  1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                           POSITIONS
              NAME                  TYPE   LENGTH BEG  END                             CONTENTS
       ---------------------------- ----  ------ --------  ----------------------------------------------------
```

```
                                        DB2 ALIAS: FI_CLM_ACTN_CD
                                        SAS ALIAS: ACTIONCD
                                        STANDARD ALIAS: FI_CLM_ACTN_CD
                                        TITLE ALIAS: ACTION_CD

                                        CODES:
                                          REFER TO: FI_CLM_ACTN_TB
                                                    IN THE CODES APPENDIX

                                        COMMENT:
                                        PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                        INTRMDRY_CLM_ACTN_CD.

                                        SOURCE:
                                        CWF

  61. FI CLAIM PROCESS DATE        NUM     8   243  250  THE DATE THE FISCAL INTERMEDIARY COMPLETES
                                                         PROCESSING AND RELEASES THE INSTITUTIONAL
                                                         CLAIM TO THE CWF HOST.

                                        8 DIGITS UNSIGNED

                                        DB2 ALIAS: FI_CLM_PROC_DT
                                        SAS ALIAS: APRVL_DT
                                        STANDARD ALIAS: FI_CLM_PROC_DT
                                        TITLE ALIAS: FI_PROCESS_DT

                                        EDIT-RULES:
                                        YYYYMMDD

                                        SOURCE:
                                        CWF

  62. NCH PROVIDER STATE CODE      CHAR    2   251  252  EFFECTIVE WITH VERSION H, THE TWO POSITION SSA STATE
                                                         WHERE PROVIDER FACILITY IS LOCATED.

                                        NOTE:  DURING THE VERSION H CONVERSION THIS FIELD WAS
                                        POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVI
                                        1991).

                                        DB2 ALIAS: NCH_PRVDR_STATE_CD
                                        SAS ALIAS: PRSTATE
                                        STANDARD ALIAS: NCH_PRVDR_STATE_CD
```

```
                                          TITLE ALIAS: PROVIDER_STATE_CD

                                          DERIVATION:
                                          DERIVED FROM:
                                            NCH PRVDR_NUM

                                          DERIVATION RULES:

                                            SET NCH_PRVDR_STATE_CD TO
                                                PRVDR_NUM POS1-2.
                                            FOR PRVDR_NUM POS1-2 EQUAL '55
                                              SET NCH_PRVDR_STATE_CD TO '05'.
    1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                 POSITIONS
            NAME             TYPE  LENGTH BEG  END                        CONTENTS
    ---------------------------- ---- ------ --------- ------------------------------------------------
                                            FOR PRVDR_NUM POS1-2 EQUAL '67
                                              SET NCH_PRVDR_STATE_CD TO '45'.
                                            FOR PRVDR_NUM POS1-2 EQUAL '68
                                              SET NCH_PRVDR_STATE_CD TO '10'.


                                          CODES:
                                            REFER TO: GEO_SSA_STATE_TB
                                                         IN THE CODES APPENDIX


                                          SOURCE:
                                          NCH


    63. ORGANIZATION NPI NUMBER     CHAR    10   253  262  A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H) FOR ST
                                                           THE NPI ASSIGNED TO THE INSTITUTIONAL PROVIDER.

                                          DB2 ALIAS: ORG_NPI_NUM
                                          SAS ALIAS: ORGNPINM
                                          STANDARD ALIAS: ORG_NPI_NUM
                                          TITLE ALIAS: ORG_NPI

                                          SOURCE:
                                          CWF


    ****   ATTENDING PHYSICIAN ID     GROUP   24   263  286  NAME AND IDENTIFICATION NUMBERS ASSOCIATED
           GROUP                                             WITH THE PRIMARY CARE PHYSICIAN.

                                          STANDARD ALIAS: ATNDG_PHYSN_ID_GRP
```

64. CLAIM ATTENDING PHYSICIAN   CHAR   6   263 268 ON AN INSTITUTIONAL CLAIM, THE UNIQUE PHYSICIAN
    UPIN NUMBER   IDENTIFICATION NUMBER (UPIN) OF THE PHYSICIAN
                                                          WHO WOULD NORMALLY BE EXPECTED TO CERTIFY AND
                                                          RECERTIFY THE MEDICAL NECESSITY OF THE SERVICES
                                                          RENDERED AND/OR WHO HAS PRIMARY RESPONSIBILITY FOR
                                                          THE BENEFICIARY'S MEDICAL CARE AND TREATMENT
                                                          (ATTENDING PHYSICIAN).

                                                          COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
                                                          DB2 ALIAS: ATNDG_UPIN
                                                          SAS ALIAS: AT_UPIN
                                                          STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
                                                          TITLE ALIAS: ATTENDING_PHYSICIAN

                                                          COMMENT:
                                                          PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                          CLM_PRMRY_CARE_PHYSN_IDENT_NUM AND CONTAINED
                                                          10 POSITIONS (6-POSITION UPIN AND 4-POSITION
                                                          PHYSICIAN SURNAME).

                                                          SOURCE:
                                                          CWF

65. CLAIM ATTENDING PHYSICIAN   CHAR   10   269 278 A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
    NPI NUMBER   FOR STORING THE NPI ASSIGNED TO THE ATTENDING
                                                          PHYSICIAN.

                                                          COMMON ALIAS: ATTENDING_PHYSICIAN_NPI

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                              POSITIONS
                 NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ --------- --
                                                          DB2 ALIAS: ATNDG_NPI
                                                          SAS ALIAS: AT_NPI
                                                          STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM
                                                          TITLE ALIAS: ATNDG_NPI

                                                          SOURCE:
                                                          CWF

66. CLAIM ATTENDING PHYSICIAN   CHAR   6   279 284 EFFECTIVE WITH VERSION H, THE LAST NAME OF THE
    SURNAME   ATTENDING PHYSICIAN (USED FOR INTERNAL EDITING

PURPOSE IN HCFA'S CWFMQA SYSTEM.)

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: ATNDG_SRNM
SAS ALIAS: AT_SRNM
STANDARD ALIAS: CLM_ATNDG_PHYSN_SRNM_NAME
TITLE ALIAS: ANDG_PHYSN_SURNAME

SOURCE:
CWF

67. CLAIM ATTENDING PHYSICIAN   CHAR   1   285 285 EFFECTIVE WITH VERSION H, THE FIRST NAME OF THE
     GIVEN NAME   ATTENDING PHYSICIAN (USED FOR INTERNAL EDITING
                                                           PURPOSES IN HCFA'S CWFMQA SYSTEM).

                                                           NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                           10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                           CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                           SPACES IN THIS FIELD.

                                                           DB2 ALIAS: ATNDG_GVN_NAME
                                                           SAS ALIAS: AT_GVNNM
                                                           STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME
                                                           TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME

                                                           SOURCE:
                                                           CWF

68. CLAIM ATTENDING PHYSICIAN   CHAR   1   286 286 EFFECTIVE WITH VERSION H, THE MIDDLE INITIAL
     MIDDLE INITIAL NAME   OF THE ATTENDING PHYSICIAN (USED FOR INTERNAL
                                                           EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)

                                                           NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                           10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                           CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                           SPACES IN THIS FIELD.

                                                           DB2 ALIAS: ATNDG_MI_NAME
                                                           SAS ALIAS: AT_MDL
                                                           STANDARD ALIAS: CLM_ATNDG_PHYSN_MDL_INITL_NAME

```
                                       TITLE ALIAS: ATNDG_PHYSN_MI

1                         FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                              POSITIONS
             NAME                 TYPE  LENGTH BEG   END                        CONTENTS
     ---------------------------- ----  ------ --------- -------------------------------------------------
                                                          SOURCE:
                                                          CWF

  ****  OPERATING PHYSICIAN ID    GROUP   24   287  310  NAME AND IDENTIFICATION NUMBERS ASSOCIATED
        GROUP                                             WITH THE PHYSICIAN WHO PERFORMED THE PRINCIPAL
                                                          PROCEDURE.

                                                          STANDARD ALIAS: OPRTG_PHYSN_ID_GRP

    69. CLAIM OPERATING PHYSICIAN  CHAR     6   287  292  ON AN INSTITUTIONAL CLAIM, THE UNIQUE PHYSICIAN
        UPIN NUMBER                                       IDENTIFICATION NUMBER (UPIN) OF THE PHYSICIAN
                                                          WHO PERFORMED THE PRINCIPAL PROCEDURE.  THIS
                                                          ELEMENT IS USED BY THE PROVIDER TO IDENTIFY THE
                                                          OPERATING PHYSICIAN WHO PERFORMED THE SURGI-
                                                          CAL PROCEDURE.

                                                          DB2 ALIAS: OPRTG_UPIN
                                                          SAS ALIAS: OP_UPIN
                                                          STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
                                                          TITLE ALIAS: OPRTG_UPIN

                                                          COMMENT:
                                                          PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                          CLM_PRNCPAL_PRCDR_PHYSN_NUM AND CONTAINED
                                                          10 POSITIONS (6-POSITION UPIN AND 4-POSITION
                                                          PHYSICIAN SURNAME.

                                                          NOTE:  FOR HHA AND HOSPICE FORMATS BEGINNING
                                                          WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD
                                                          WAS POPULATED WITH DATA.  HHA AND HOSPICE CLAIMS
                                                          PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES.

                                                          SOURCE:
                                                          CWF

    70. CLAIM OPERATING PHYSICIAN  CHAR    10   293  302  A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
        NPI NUMBER                                        FOR STORING THE NPI ASSIGNED TO THE OPERATING
```

```
                                                PHYSICIAN.

                                                DB2 ALIAS: OPRTG_NPI
                                                SAS ALIAS: OP_NPI
                                                STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM
                                                TITLE ALIAS: OPRTG_NPI

                                                SOURCE:
                                                CWF
```

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  71. CLAIM OPERATING PHYSICIAN     CHAR     6   303  308  EFFECTIVE WITH VERSION H, THE LAST NAME OF THE
      SURNAME                                              OPERATING PHYSICIAN (USED FOR INTERNAL EDITING
                                                           PURPOSES IN HCFA'S CWFMQA SYSTEM.)

                                                           NOTE:  BEGINNING WITH THE NCH WEEKLY PROCESS DATE
                                                           10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                           CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                           SPACES IN THIS FIELD.
```

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1                       FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                              POSITIONS
            NAME                  TYPE  LENGTH BEG   END                         CONTENTS
  ---------------------------     ----  ------ ---------  -------------------------------------------------
                                                           DB2 ALIAS: OPRTG_SRNM
                                                           SAS ALIAS: OP_SRNM
                                                           STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME
                                                           TITLE ALIAS: OPRTG_PHYSN_SURNAME

                                                           SOURCE:
                                                           CWF
```

```
  72. CLAIM OPERATING PHYSICIAN     CHAR     1   309  309  EFFECTIVE WITH VERSION H, THE FIRST NAME
      GIVEN NAME                                           OF THE OPERATING PHYSICIAN (USED FOR INTERNAL
                                                           EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)

                                                           NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                           10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                           CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                           SPACES IN THIS FIELD.

                                                           DB2 ALIAS: OPRTG_GVN_NAME
                                                           SAS ALIAS: OP_GVN
                                                           STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME
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                                                      TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME

                                                      SOURCE:
                                                      CWF

  73. CLAIM OPERATING PHYSICIAN      CHAR    1   310  310  EFFECTIVE WITH VERSION H, THE MIDDLE INITIAL
      MIDDLE INITIAL NAME                                  OF THE OPERATING PHYSICIAN (USED FOR INTERNAL
                                                           EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)

                                                      NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                      10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                      CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                      SPACES IN THIS FIELD.

                                                      DB2 ALIAS: OPRTG_MI_NAME
                                                      SAS ALIAS: OP_MDL
                                                      STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME
                                                      TITLE ALIAS: OPRTG_PHYSN_MI

                                                      SOURCE:
                                                      CWF

 ****  OTHER PHYSICIAN ID GROUP      GROUP   24  311  334  NAME AND IDENTIFICATION NUMBERS ASSOCIATED WITH THE O
                                                           PHYSICIAN.

                                                      STANDARD ALIAS: OTHR_PHYSN_ID_GRP

  74. CLAIM OTHER PHYSICIAN UPIN      CHAR    6   311  316  ON AN INSTITUTIONAL CLAIM, THE UNIQUE PHYSICIAN
      NUMBER                                               IDENTIFICATION NUMBER (UPIN) OF THE OTHER
                                                           PHYSICIAN ASSOCIATED WITH THE INSTITUTIONAL
                                                           CLAIM.

                                                      DB2 ALIAS: OTHR_UPIN
                                                      SAS ALIAS: OT_UPIN
                                                      STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
                                                      TITLE ALIAS: OTH_PHYSN_UPIN
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                              POSITIONS
            NAME                  TYPE   LENGTH BEG   END                        CONTENTS
    ----------------------------  ----   ------ --------  ----------------------------------------------------

                                                      COMMENT:
                                                      PRIOR TO VERSION H THIS FIELD WAS NAMED:
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                                              CLM_OTHR_PHYSN_IDENT_NUM AND CONTAINED
                                              10 POSITIONS (6-POSITION UPIN AND 4-POSITION
                                              OTHER PHYSICIAN SURNAME).

                                              NOTE:  FOR HHA AND HOSPICE FORMATS BEGINNING
                                              WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD
                                              WAS POPULATED WITH DATA.  HHA AND HOSPICE CLAIMS
                                              PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES.

                                              SOURCE:
                                              CWF

75. CLAIM OTHER PHYSICIAN NPI   CHAR   10   317  326  A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H
    NUMBER                                           FOR STORING THE NPI ASSIGNED TO THE OTHER
                                                     PHYSICIAN.

                                              DB2 ALIAS: OTHR_NPI
                                              SAS ALIAS: OT_NPI
                                              STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM

                                              SOURCE:
                                              CWF

76. CLAIM OTHER PHYSICIAN       CHAR    6   327  332  EFFECTIVE WITH VERSION H, THE LAST NAME OF THE
    SURNAME                                          OTHER PHYSICIAN (USED FOR INTERNAL EDITING
                                                     PURPOSES IN HCFA'S CWFMQA SYSTEM.)

                                              NOTE:  BEGINNING WITH THE NCH WEEKLY PROCESS DATE
                                              10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                              CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                              SPACES IN THIS FIELD.

                                              DB2 ALIAS: OTHR_SRNM
                                              SAS ALIAS: OT_SRNM
                                              STANDARD ALIAS: CLM_OTHR_PHYSN_SRNM_NAME
                                              TITLE ALIAS: OTH_PHYSN_SURNAME

                                              SOURCE:
                                              CWF

77. CLAIM OTHER PHYSICIAN GIVEN CHAR    1   333  333  EFFECTIVE WITH VERSION H, THE FIRST NAME OF THE
    NAME                                             OTHER PHYSICIAN (USED FOR INTERNAL EDITING
                                                     PURPOSES IN HCFA'S CWFMQA SYSTEM.)
```

```
                                        NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                        10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                        CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                        SPACES IN THIS FIELD.

                                        DB2 ALIAS: OTHR_GVN_NAME
                                        SAS ALIAS: OT_GVN
                                        STANDARD ALIAS: CLM_OTHR_PHYSN_GVN_NAME
                                        TITLE ALIAS: OTH_PHYSN_FIRSTNAME
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                             POSITIONS
           NAME                  TYPE  LENGTH BEG   END                       CONTENTS
    --------------------------   ----  ------ --------   --------------------------------------------------

                                        SOURCE:
                                        CWF

  78. CLAIM OTHER PHYSICIAN      CHAR     1   334   334  EFFECTIVE WITH VERSION H, THE MIDDLE INITIAL OF
      MIDDLE INITIAL NAME                                THE OTHER PHYSICIAN (USED FOR INTERNAL EDITING
                                                         PURPOSES IN HCFA'S CWFMQA SYSTEM.)

                                        NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                        10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                        CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                        SPACES IN THIS FIELD.

                                        DB2 ALIAS: OTHR_MI_NAME
                                        SAS ALIAS: OT_MDL
                                        STANDARD ALIAS: CLM_OTHR_PHYSN_MDL_INITL_NAME
                                        TITLE ALIAS: OTH_PHYSN_MI

                                        SOURCE:
                                        CWF

  79. MEDICAID PROVIDER          CHAR    13   335   347  A UNIQUE IDENTIFICATION NUMBER ASSIGNED TO EACH PROVI
      IDENTIFICATION NUMBER                              THE STATE MEDICAID AGENCY.  THIS UNIQUE PROVIDER NUMB
                                                         USED TO ENSURE PROPER PAYMENT OF PROVIDERS AND TO MAI
                                                         CLAIMS HISTORY ON INDIVIDUAL PROVIDERS FOR SURVEILLAN
                                                         UTILIZATION REVIEW.

                                        DB2 ALIAS: MDCD_PRVDR_NUM
                                        SAS ALIAS: MDCD_PRV
                                        STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM
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```
                                             TITLE ALIAS: MEDICAID_PROVIDER

                                             COMMENT:
                                             PRIOR TO VERSION H THE FIELD SIZE WAS X(12).

                                             SOURCE:
                                             CWF

 80. CLAIM MEDICAID INFORMATION   CHAR    4   348  351 EFFECTIVE WITH VERSION G, CODE IDENTIFYING MEDICAID
     CODE                                             INFORMATION SUPPLIED BY THE CONTRACTOR TO MEDICAID.

                                             DB2 ALIAS: CLM_MDCD_INFO_CD
                                             SAS ALIAS: MDCDINFO
                                             STANDARD ALIAS: CLM_MDCD_INFO_CD
                                             TITLE ALIAS: MEDICAID_INFO

                                             SOURCE:
                                             CWF

 81. CLAIM MCO PAID SWITCH        CHAR    1   352  352 A SWITCH INDICATING WHETHER OR NOT A MANAGED CARE
                                                       ORGANIZATION (MCO) HAS PAID THE PROVIDER FOR AN
                                                       INSTITUTIONAL CLAIM.

                                             COBOL ALIAS: MCO_PD_IND
                                             DB2 ALIAS: CLM_MCO_PD_SW
                                             SAS ALIAS: MCOPDSW
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 1                         FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                  POSITIONS
                NAME              TYPE  LENGTH BEG  END                          CONTENTS
     ----------------------------- ----  ------ --------- ----------------------------------------------------
                                             STANDARD ALIAS: CLM_MCO_PD_SW
                                             TITLE ALIAS: MCO_PAID_SW

                                             CODES:
                                             1 = MCO HAS PAID THE PROVIDER FOR A CLAIM
                                             BLANK OR 0 = MCO HAS NOT PAID THE PROVIDER
                                                          FOR A CLAIM

                                             COMMENT:
                                             PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                             CLM_GHO_PD_SW.

                                             SOURCE:
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```
                                                            CWF

    82.  CLAIM TREATMENT              CHAR    18   353  370   THE NUMBER ASSIGNED BY THE MEDICAL REVIEWER AND
         AUTHORIZATION NUMBER                                 REPORTED BY THE PROVIDER TO IDENTIFY THE
                                                             MEDICAL REVIEW (TREATMENT AUTHORIZATION)
                                                             ACTION TAKEN AFTER REVIEW OF THE BENEFICIARY'S
                                                             CASE.  IT DESIGNATES THAT TREATMENT COVERED
                                                             BY THE BILL HAS BEEN AUTHORIZED BY THE PAYER.
                                                             THIS NUMBER IS USED BY THE INTERMEDIARY AND
                                                             THE PEER REVIEW ORGANIZATION.

                                                             NOTE:  UNDER HH PPS THIS FIELD WILL BE USED TO
                                                             LINK CLAIMS TO THE OASIS ASSESSMENT USED AS THE
                                                             BASIS OF PAYMENT.  THIS EIGHTEEN CHARACTER STRING
                                                             CONSISTS OF THE START OF CARE DATE, THE OASIS
                                                             ASSESSMENT DATE AND THE TWO DIGIT REASON FOR
                                                             ASSESSMENT CODE.

                                                             COMMON ALIAS: TAN
                                                             DB2 ALIAS: TRTMT_AUTHRZTN_NUM
                                                             SAS ALIAS: AUTHRZTN
                                                             STANDARD ALIAS: CLM_TRTMT_AUTHRZTN_NUM
                                                             TITLE ALIAS: TREATMENT_AUTHORIZATION

                                                             SOURCE:
                                                             CWF

    83.  PATIENT CONTROL NUMBER       CHAR    20   371  390   THE UNIQUE ALPHANUMERIC IDENTIFIER ASSIGNED BY THE
                                                             PROVIDER TO THE INSTITUTIONAL CLAIM TO FACILITATE
                                                             RETRIEVAL OF INDIVIDUAL CASE RECORDS AND POSTING
                                                             OF PAYMENTS.

                                                             DB2 ALIAS: PTNT_CNTL_NUM
                                                             SAS ALIAS: PTNTCNTL
                                                             STANDARD ALIAS: PTNT_CNTL_NUM
                                                             TITLE ALIAS: PATIENT_CONTROL_NUM

                                                             SOURCE:
                                                             CWF

    84.  CLAIM MEDICAL RECORD NUMBER  CHAR    17   391  407   THE NUMBER ASSIGNED BY THE PROVIDER TO THE
                                                             BENEFICIARY'S MEDICAL RECORD TO ASSIST IN RECORD
                                                             RETRIEVAL.
1                         FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001
```

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                                           POSITIONS
            NAME                 TYPE  LENGTH BEG   END                        CONTENTS
     ---------------------------- ----  ------ ---------  -------------------------------------------------
                                                          DB2 ALIAS: CLM_MDCL_REC_NUM
                                                          SAS ALIAS: MDCL_REC
                                                          STANDARD ALIAS: CLM_MDCL_REC_NUM
                                                          TITLE ALIAS: MEDICAL_RECORD_NUM

                                                          SOURCE:
                                                          CWF

     85. CLAIM PRO CONTROL NUMBER   CHAR    12    408   419  EFFECTIVE WITH VERSION G, THE UNIQUE IDENTIFIER
                                                          ASSIGNED BY THE PEER REVIEW ORGANIZATION (PRO)
                                                          FOR CONTROL PURPOSES.

                                                          DB2 ALIAS: CLM_PRO_CNTL_NUM
                                                          SAS ALIAS: PRO_CNTL
                                                          STANDARD ALIAS: CLM_PRO_CNTL_NUM
                                                          TITLE ALIAS: PRO_CONTROL_NUM

                                                          SOURCE:
                                                          CWF

     86. CLAIM PRO PROCESS DATE     NUM      8    420   427  EFFECTIVE WITH VERSION H, THE DATE THE CLAIM WAS
                                                          USED IN THE PRO REVIEW PROCESS.

                                                          NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                          10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                          CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                          ZEROES IN THIS FIELD.

                                                          8 DIGITS UNSIGNED

                                                          DB2 ALIAS: CLM_PRO_PROC_DT
                                                          SAS ALIAS: PRO_DT
                                                          STANDARD ALIAS: CLM_PRO_PROC_DT
                                                          TITLE ALIAS: PRO_PROC_DT

                                                          EDIT-RULES:
                                                          YYYYMMDD

                                                          SOURCE:
```

```
                                                 CWF

    87.  PATIENT DISCHARGE STATUS      CHAR    2   428  429  THE CODE USED TO IDENTIFY THE STATUS OF THE
         CODE                                                PATIENT AS OF THE CLM_THRU_DT.

                                                            COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
                                                            DB2 ALIAS: PTNT_DSCHRG_STUS
                                                            SAS ALIAS: STUS_CD
                                                            STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
                                                            SYSTEM ALIAS: LTCLMST
                                                            TITLE ALIAS: PTNT_DSCHRG_STUS_CD

                                                            CODES:
                                                              REFER TO: PTNT_DSCHRG_STUS_TB
                                                                         IN THE CODES APPENDIX

    1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                                 POSITIONS
                    NAME                   TYPE  LENGTH BEG  END                        CONTENTS
         ---------------------------- ---- ------ --------- ----------------------------------------------------
                                                            COMMENT:
                                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                            CLM_STUS_CD.

                                                            SOURCE:
                                                            CWF

    88.  CLAIM DIAGNOSIS E CODE        CHAR    5   430  434  EFFECTIVE WITH VERSION H, THE ICD-9-CM CODE
                                                            USED TO IDENTIFY THE EXTERNAL CAUSE OF INJURY,
                                                            POISONING, OR OTHER ADVERSE AFFECT.  REDUNDANTLY
                                                            THIS FIELD IS ALSO STORED AS THE LAST OCCURRENCE
                                                            OF THE DIAGNOSIS TRAILER.

                                                            NOTE:  DURING THE VERSION H CONVERSION, THE DATA
                                                            IN THE LAST OCCURRENCE OF THE DIAGNOSIS TRAILER
                                                            WAS USED TO POPULATE HISTORY.

                                                            DB2 ALIAS: CLM_DGNS_E_CD
                                                            SAS ALIAS: DGNS_E
                                                            STANDARD ALIAS: CLM_DGNS_E_CD
                                                            TITLE ALIAS: DGNS_E_CD

                                                            SOURCE:
```

```
                                          CWF

   89. FILLER                       CHAR     1   435  435

   90. CLAIM PPS INDICATOR CODE     CHAR     1   436  436   EFFECTIVE WITH VERSION H, THE CODE INDICATING
                                                            WHETHER OR NOT THE (1) CLAIM IS PPS AND/OR (2)
                                                            THE BENEFICIARY IS A DEEMED INSURED MEDICARE
                                                            QUALIFIED GOVERNMENT EMPLOYEE (MQGE).

                                                            NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                            10/3/97 THROUGH 5/29/98, THIS FIELD WAS POP-
                                                            ULATED WITH ONLY THE PPS INDICATOR.  BEGINNING WITH
                                                            NCH WEEKLY PROCESS DATE 6/5/98, THIS FIELD WAS
                                                            ADDITIONALLY POPULATED WITH THE DEEMED MQGE
                                                            INDICATOR. CLAIMS PROCESSED PRIOR TO 10/3/97
                                                            WILL CONTAIN SPACES.

                                                            COBOL ALIAS: PPS_IND
                                                            DB2 ALIAS: CLM_PPS_IND_CD
                                                            SAS ALIAS: PPS_IND
                                                            STANDARD ALIAS: CLM_PPS_IND_CD
                                                            TITLE ALIAS: PPS_IND

                                                            CODES:
                                                              REFER TO: CLM_PPS_IND_TB
                                                                        IN THE CODES APPENDIX

                                                            SOURCE:
                                                            CWF

   91. CLAIM TOTAL CHARGE AMOUNT    PACK     6   437  442   EFFECTIVE WITH VERSION G, THE TOTAL CHARGES FOR
                                                            ALL SERVICES INCLUDED ON THE INSTITUTIONAL CLAIM.
                                                            THIS FIELD IS REDUNDANT WITH REVENUE CENTER
1                       FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                           POSITIONS
            NAME                   TYPE  LENGTH BEG   END                        CONTENTS
   ---------------------------- ---- ------ --------  -------------------------------------------------------
                                                            CODE 0001/TOTAL CHARGES.

                                                            9.2 DIGITS SIGNED

                                                            DB2 ALIAS: CLM_TOT_CHRG_AMT
                                                            SAS ALIAS: TOT_CHRG
```

STANDARD ALIAS: CLM_TOT_CHRG_AMT
TITLE ALIAS: CLAIM_TOTAL_CHARGES

COMMENT:
PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS
S9(7)V99.

SOURCE:
CWF

92. FILLER   CHAR   50   443 492

93. OUTPATIENT NCH EDIT CODE   NUM   2   493 494   THE COUNT OF HOW MANY CLAIM EDIT TRAILERS
    COUNT   PRESENT ON AN OUTPATIENT CLAIM DURING THE
                                                                QUALITY ASSURANCE PROCESS. THE PURPOSE OF
                                                                THIS COUNT IS TO INDICATE HOW MANY CLAIM
                                                                EDIT TRAILERS ARE PRESENT.

                                                                2 DIGITS UNSIGNED

                                                                DB2 ALIAS: OP_NCH_EDIT_CD_CNT
                                                                SAS ALIAS: OPEDCNT
                                                                STANDARD ALIAS: OP_NCH_EDIT_CD_CNT

                                                                SOURCE:
                                                                NCH

94. OUTPATIENT NCH PATCH CODE   NUM   2   495 496   EFFECTIVE WITH VERSION H, THE COUNT OF THE
    COUNT   NUMBER OF HCFA PATCH CODES ANNOTATED TO THE
                                                                OUTPATIENT CLAIM DURING THE NEARLINE
                                                                MAINTENANCE PROCESS.   THE PURPOSE OF THIS
                                                                COUNT IS TO INDICATE HOW MANY NCH PATCH
                                                                TRAILERS ARE PRESENT.

                                                                NOTE1: DURING THE VERSION H CONVERSION THIS
                                                                FIELD WAS POPULATED WITH DATA THROUGHOUT
                                                                HISTORY (BACK TO SERVICE YEAR 1991).

                                                                NOTE2: EFFECTIVE WITH VERSION 'I' THE NUMBER
                                                                OF POSSIBLE OCCURRENCES WAS REDUCED TO 30.
                                                                PRIOR TO VERSION 'I' THE NUMBER OF POSSIBLE
                                                                OCCURRENCES WAS 99.

                                                                2 DIGITS UNSIGNED

```
                                             DB2 ALIAS: OP_PATCH_CD_CNT
                                             SAS ALIAS: OPPATCNT
                                             STANDARD ALIAS: OP_NCH_PATCH_CD_I_CNT

                                             SOURCE:
1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                         POSITIONS
             NAME                TYPE  LENGTH BEG  END                         CONTENTS
    ----------------------------  ----  ------ ---------  -------------------------------------------------
                                                          NCH

   95. OUTPATIENT MCO PERIOD COUNT  NUM     1   497  497  EFFECTIVE WITH VERSION H, THE COUNT OF THE
                                                          NUMBER OF MANAGED CARE ORGANIZATION (MCO)
                                                          PERIODS REPORTED ON AN OUTPATIENT CLAIM.
                                                          THE PURPOSE OF THIS COUNT IS TO INDICATE
                                                          HOW MANY MCO PERIOD TRAILERS ARE PRESENT.

                                                          NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                          10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                          CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                          ZEROES IN THIS FIELD.

                                                          1 DIGIT UNSIGNED

                                                          DB2 ALIAS: OP_MCO_PRD_CNT
                                                          SAS ALIAS: OPMCOCNT
                                                          STANDARD ALIAS: OP_MCO_PRD_CNT

                                                          EDIT-RULES:
                                                          RANGE: 0 TO 2

                                                          SOURCE:
                                                          NCH

   96. OUTPATIENT CLAIM HEALTH     NUM     1   498  498  A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
       PLANID COUNT                                       FOR STORING THE COUNT OF THE NUMBER OF HEALTH
                                                          PLANIDS REPORTED ON THE OUTPATIENT CLAIM.  THE
                                                          PURPOSE OF THIS COUNT IS TO INDICATE HOW MANY
                                                          HEALTH PLANID TRAILERS ARE PRESENT. NOTE: PRIOR
                                                          TO VERSION 'I' THIS FIELD WAS NAMED:
                                                          OP_CLM_PAYERID_CNT.
```

```
                                                 1 DIGIT UNSIGNED

                                                 DB2 ALIAS: OP_CLM_PLANID_CNT
                                                 SAS ALIAS: OPPLNCNT
                                                 STANDARD ALIAS: OP_CLM_HLTH_PLANID_CNT

                                                 EDIT-RULES:
                                                 RANGE: 0 TO 3

                                                 SOURCE:
                                                 NCH

    97. OUTPATIENT CLAIM            NUM     1   499  499  EFFECTIVE WITH VERSION H, THE COUNT OF THE NUMBER
        DEMONSTRATION ID COUNT                            OF CLAIM DEMONSTRATION IDS REPORTED ON AN
                                                          OUTPATIENT CLAIM.  THE PURPOSE OF THIS COUNT
                                                          IS TO INDICATE HOW MANY CLAIM DEMONSTRATION
                                                          TRAILERS ARE PRESENT.

                                                          NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                          WAS POPULATED WITH DATA WHERE A DEMO WAS
                                                          IDENTIFIABLE.

                                                 1 DIGIT UNSIGNED
  1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                             POSITIONS
              NAME                  TYPE  LENGTH BEG   END                         CONTENTS
    ---------------------------     ----  ------ --------   -----------------------------------------------------

                                                 DB2 ALIAS: OP_CLM_DEMO_ID_CNT
                                                 SAS ALIAS: OPDEMCNT
                                                 STANDARD ALIAS: OP_CLM_DEMO_ID_CNT

                                                 EDIT-RULES:
                                                 RANGE: 0 TO 5

                                                 SOURCE:
                                                 NCH

    98. OUTPATIENT CLAIM DIAGNOSIS  NUM     2   500  501  THE COUNT OF THE NUMBER OF DIAGNOSIS CODES (BOTH
        CODE COUNT                                        PRINCIPAL AND OTHER) REPORTED ON AN OUTPATIENT
                                                          CLAIM.  THE PURPOSE OF THIS COUNT IS TO INDICATE
                                                          HOW MANY CLAIM DIAGNOSIS TRAILERS ARE PRESENT.
```

```
                                            2 DIGITS UNSIGNED

                                            DB2 ALIAS: OP_CLM_DGNS_CD_CNT
                                            SAS ALIAS: OPDGNCNT
                                            STANDARD ALIAS: OP_CLM_DGNS_CD_CNT

                                            EDIT-RULES:
                                            RANGE: 0 TO 10

                                            COMMENT:
                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                            CLM_OTHR_DGNS_CD_CNT AND THE PRINCIPAL WAS
                                            NOT INCLUDED IN THE COUNT.

                                            SOURCE:
                                            NCH

    99. OUTPATIENT CLAIM PROCEDURE   NUM     2   502  503  THE COUNT OF THE NUMBER OF PROCEDURE CODES (BOTH
        CODE COUNT                                         PRINCIPAL AND OTHER) REPORTED ON AN OUTPATIENT
                                                           CLAIM.  THE PURPOSE OF THIS COUNT IS TO INDICATE
                                                           HOW MANY CLAIM PROCEDURE TRAILERS ARE PRESENT.

                                            2 DIGITS UNSIGNED

                                            DB2 ALIAS: OP_PRCDR_CD_CNT
                                            SAS ALIAS: OPPRCCNT
                                            STANDARD ALIAS: OP_CLM_PRCDR_CD_CNT

                                            EDIT-RULES:
                                            RANGE: 0 TO 6

                                            COMMENT:
                                            PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                            CLM_PRCDR_CD_CNT.

                                            SOURCE:
                                            CWF

   100. OUTPATIENT CLAIM RELATED      NUM     2   504  505  THE COUNT OF THE NUMBER OF CONDITION CODES
        CONDITION CODE COUNT                                REPORTED ON AN OUTPATIENT CLAIM.  THE
  1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                      POSITIONS
            NAME                  TYPE  LENGTH BEG  END                                 CONTENTS
```

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     -------------------------  ----  ------ --------  ------------------------------------------------------
                                                       PURPOSE OF THIS COUNT IS TO INDICATE HOW
                                                       MANY CONDITION CODE TRAILERS ARE PRESENT.

                                                       2 DIGITS UNSIGNED

                                                       DB2 ALIAS: OP_RLT_COND_CD_CNT
                                                       SAS ALIAS: OPCONCNT
                                                       STANDARD ALIAS: OP_CLM_RLT_COND_CD_CNT

                                                       EDIT-RULES:
                                                       RANGE: 0 TO 30

                                                       COMMENT:
                                                       PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                       CLM_RLT_COND_CD_CNT.

                                                       SOURCE:
                                                       NCH

101. OUTPATIENT CLAIM RELATED     NUM    2   506  507  THE COUNT OF THE NUMBER OF OCCURRENCE CODES
     OCCURRENCE CODE COUNT                             REPORTED ON AN OUTPATIENT CLAIM.  THE
                                                       PURPOSE OF THIS COUNT IS TO INDICATE HOW
                                                       MANY OCCURRENCE CODE TRAILERS ARE PRESENT.

                                                       2 DIGITS UNSIGNED

                                                       DB2 ALIAS: OP_OCRNC_CD_CNT
                                                       SAS ALIAS: OPOCRCNT
                                                       STANDARD ALIAS: OP_CLM_RLT_OCRNC_CD_CNT

                                                       EDIT-RULES:
                                                       RANGE: 0 TO 30

                                                       COMMENT:
                                                       PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                       CLM_RLT_OCRNC_CD_CNT.

                                                       SOURCE:
                                                       NCH

102. OUTPATIENT CLAIM OCCURRENCE  NUM    2   508  509  THE COUNT OF THE NUMBER OF OCCURRENCE SPAN CODES
     SPAN CODE COUNT                                   REPORTED ON AN OUTPATIENT CLAIM.  THE PURPOSE
                                                       OF THE COUNT IS TO INDICATE HOW MANY SPAN CODE
```

```
                                                    TRAILERS ARE PRESENT.

                                                    2 DIGITS UNSIGNED

                                                    DB2 ALIAS: OP_OCRNC_SPAN_CNT
                                                    SAS ALIAS: OPSPNCNT
                                                    STANDARD ALIAS: OP_CLM_OCRNC_SPAN_CD_CNT

                                                    COMMENT:
                                                    PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                    CLM_OCRNC_SPAN_CD_CNT.

                                                    SOURCE:
   1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                        POSITIONS
            NAME                TYPE  LENGTH BEG  END                            CONTENTS
   ----------------------------  ----  ------ ---------  ------------------------------------------------------
                                                    NCH

  103. OUTPATIENT CLAIM VALUE CODE   NUM      2   510  511  THE COUNT OF THE NUMBER OF VALUE CODES REPORTED ON
       COUNT                                               AN OUTPATIENT CLAIM.  THE PURPOSE OF THE COUNT
                                                           IS TO INDICATE HOW MANY VALUE CODE TRAILERS ARE
                                                           PRESENT.

                                                    2 DIGITS UNSIGNED

                                                    DB2 ALIAS: OP_CLM_VAL_CD_CNT
                                                    SAS ALIAS: OPVALCNT
                                                    STANDARD ALIAS: OP_CLM_VAL_CD_CNT

                                                    EDIT-RULES:
                                                    RANGE: 0 TO 36

                                                    COMMENT:
                                                    PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                    CLM_VAL_CD_CNT.

                                                    SOURCE:
                                                    NCH

  104. OUTPATIENT REVENUE CENTER    NUM      2   512  513  THE COUNT OF THE NUMBER OF REVENUE CODES
       CODE COUNT                                          REPORTED ON AN INPATIENT/SNF CLAIM.  THE
                                                           PURPOSE OF THE COUNT IS TO INDICATE HOW
```

```
                                              MANY REVENUE CENTER TRAILERS ARE PRESENT.

                                              2 DIGITS UNSIGNED

                                              DB2 ALIAS: OP_REV_CNTR_CD_CNT
                                              SAS ALIAS: OPREVCNT
                                              STANDARD ALIAS: OP_REV_CNTR_CD_I_CNT

                                              EDIT-RULES:
                                              RANGE: 0 TO 45

                                              COMMENT:
                                              PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                              CLM_REV_CNTR_CD_CNT.

                                              NOTE:  DURING THE VERSION 'I' CONVERSION THE
                                              NUMBER OF OCCURRENCES CHANGED TO 45 (PER SEG-
                                              MENT - 450 TOTAL FOR CLAIM).   FOR CLAIMS PRIOR
                                              TO VERSION 'I' THE NUMBER OF OCCURRENCES WAS 58.

                                              SOURCE:
                                              NCH

  105. FILLER                      CHAR     4   514  517

 ****  FI OUTPATIENT CLAIM         GROUP   78   518  595  DATA PERTAINING ONLY TO FISCAL INTERMEDIARY
       SPECIFIC GROUP                                     OUTPATIENT CLAIMS.

                                                          STANDARD ALIAS: FI_OP_CLM_SPECF_GRP

 1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                             POSITIONS
            NAME                  TYPE  LENGTH BEG   END                        CONTENTS
   -----------------------------  ----  ------ ---------  -------------------------------------------------
  106. CLAIM OUTPATIENT SERVICE   CHAR     1   518  518  CODE INDICATING TYPE AND PRIORITY OF OUTPATIENT
       TYPE CODE                                         SERVICE.

                                                         DB2 ALIAS: OP_SRVC_TYPE_CD
                                                         SAS ALIAS: OPSRVTYP
                                                         STANDARD ALIAS: CLM_OP_SRVC_TYPE_CD
                                                         TITLE ALIAS: OP_SERVICE_TYPE_CODE

                                                         CODES:
```

```
                                    REFER TO: CLM_OP_SRVC_TYPE_TB
                                              IN THE CODES APPENDIX

107. CLAIM OUTPATIENT REFERRAL    CHAR   1   519  519  THE CODE INDICATING THE MEANS BY WHICH THE
     CODE                                               BENEFICIARY WAS REFERRED FOR OUTPATIENT
                                                        SERVICES.

                                                        DB2 ALIAS: CLM_OP_RFRL_CD
                                                        SAS ALIAS: OP_RFRL
                                                        STANDARD ALIAS: CLM_OP_RFRL_CD
                                                        SYSTEM ALIAS: LTORFRL
                                                        TITLE ALIAS: OP_REFERRAL_CODE

                                                        CODES:
                                                          REFER TO: CLM_OP_RFRL_TB
                                                                    IN THE CODES APPENDIX

                                                        SOURCE:
                                                        CWF

108. NCH BENEFICIARY BLOOD        PACK   6   520  525  THE AMOUNT OF MONEY FOR WHICH THE INTERMEDIARY
     DEDUCTIBLE LIABILITY AMOUNT                        DETERMINED THE BENEFICIARY IS LIABLE FOR THE BLOOD
                                                        DEDUCTIBLE.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: BLOOD_DDCTBL_AMT
                                                        SAS ALIAS: BLDDEDAM
                                                        STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
                                                        TITLE ALIAS: BLOOD_DEDUCTIBLE

                                                        DERIVATION:
                                                        DERIVED FROM:
                                                          CLM_VAL_CD
                                                          CLM_VAL_AMT

                                                        DERIVATION RULES:
                                                        BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
                                                        '06' MOVE THE CORRESPONDING VALUE AMOUNT TO
                                                        NCH_BENE_BLOOD_DDCTBL_AMT.

                                                        COMMENT:
                                                        PRIOR TO VERSION H, THIS FIELD WAS NAMED:
                                                        BENE_BLOOD_DDCTBL_LBLTY_AMT AND THE FIELD
```

```
                                                SIZE WAS S9(5)V99.  ALSO, FOR OP CLAIMS, THIS
                                                FIELD WAS STORED IN A BLOOD TRAILER.  VERSION
                                                H ELIMINATED THE OP BLOOD TRAILER.
 1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
                 NAME                 TYPE  LENGTH BEG  END                      CONTENTS
    ---------------------------- ---- ------ -------- -------------------------------------------------

                                                SOURCE:
                                                NCH QA PROCESS


   109. NCH BENEFICIARY PART B     PACK    6   526  531  THE AMOUNT OF MONEY FOR WHICH THE
        DEDUCTIBLE AMOUNT                                INTERMEDIARY OR CARRIER HAS DETERMINED THAT
                                                         THE BENEFICIARY IS LIABLE FOR THE PART B
                                                         CASH DEDUCTIBLE ON THE CLAIM.

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: NCH_PTB_DDCTBL_AMT
                                                         SAS ALIAS: PTB_DED
                                                         STANDARD ALIAS: NCH_BENE_PTB_DDCTBL_AMT
                                                         TITLE ALIAS: PTB_DDCTBL

                                                         EDIT-RULES:
                                                         $$$$$$$$$CC

                                                         DERIVATION:
                                                         DERIVED FROM:
                                                            CLM_VAL_CD
                                                            CLM_VAL_AMT

                                                         DERIVATION RULES (EFFECTIVE 10/93):
                                                         BASED ON THE PRESENCE OF VALUE CODES A1, B1 OR C1
                                                         MOVE THE RELATED VALUE AMOUNT TO THE
                                                         NCH_BENE_PTB_DDCTBL_AMT.  *NOTE: PRIOR TO
                                                         10/93, THIS FIELD WAS PRESENT ON THE CLAIM
                                                         TRANSMITTED BY CWF.

                                                         COMMENT:
                                                         PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                         BENE_PTB_DDCTBL_LBLTY_AMT AND FIELD SIZE
                                                         WAS S9(5)V99.
```

```
                                                        SOURCE:
                                                        NCH QA PROCESS

    110.  NCH BENEFICIARY PART B        PACK     6    532  537   THE AMOUNT OF MONEY FOR WHICH THE INTERMEDIARY HAS
          COINSURANCE AMOUNT                                     DETERMINED THAT THE BENEFICIARY IS LIABLE FOR PART B
                                                                COINSURANCE ON THE INSTITUTIONAL CLAIM.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: PTB_COINSRNC_AMT
                                                        SAS ALIAS: PTB_COIN
                                                        STANDARD ALIAS: NCH_BENE_PTB_COINSRNC_AMT
                                                        TITLE ALIAS: BENE_PTB_COINSURANCE_AMT

                                                        EDIT-RULES:
                                                        $$$$$$$$$CC

                                                        DERIVATION:
                                                        DERIVED FROM:
                                                           CLM_VAL_CD
    1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                POSITIONS
                NAME                    TYPE   LENGTH BEG   END                          CONTENTS
        ----------------------------   ----   ------ --------   ----------------------------------------------------
                                                           CLM_VAL_AMT

                                                        DERIVATION RULES (EFFECTIVE 10/93):
                                                        BASED ON THE PRESENCE OF VALUE CODES A2, B2 OR C2
                                                        MOVE THE RELATED VALUE AMOUNT TO THE
                                                        NCH_BENE_PTB_COINSRNC_AMT.  *NOTE: PRIOR TO
                                                        10/93, THIS FIELD WAS PRESENT ON THE CLAIM
                                                        TRANSMITTED BY CWF.

                                                        COMMENT:
                                                        PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                        BENE_PTB_COINSRNC_LBLTY_AMT AND THE FIELD
                                                        SIZE WAS S9(5)V99.

                                                        SOURCE:
                                                        NCH QA PROCESS

    111.  NCH PROFESSIONAL COMPONENT    PACK     6    538  543   EFFECTIVE WITH VERSION H, FOR INPATIENT AND OUT-
          CHARGE AMOUNT                                          PATIENT CLAIMS, THE AMOUNT OF PHYSICIAN AND OTHER
```

PROFESSIONAL CHARGES COVERED UNDER MEDICARE PART B
(USED FOR INTERNAL CWFMQA EDITING PURPOSES AND OTHER
INTERNAL PROCESSES (E.G. IF COMPUTING INTERIM PAYMENT
THESE CHARGES ARE DEDUCTED)).

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO
SERVICE YEAR 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: PROFNL_CMPNT_AMT
SAS ALIAS: PCCHGAMT
STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT
TITLE ALIAS: PROFNL_CMPNT_CHARGES

DERIVATION:

1. IF INPATIENT - DERIVED FROM:
   CLM_VAL_CD
   CLM_VAL_AMT

DERIVATION RULES:
BASED ON THE PRESENCE OF VALUE CODE 04 OR 05
MOVE THE RELATED VALUE AMOUNT TO THE
NCH_PROFNL_CMPNT_CHRG_AMT.

2. IF OUTPATIENT - DERIVED FROM:
   REV_CNTR_CD
   REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES (EFFECTIVE 10/98):
BASED ON THE PRESENCE OF REVENUE CENTER CODES
096X, 097X & 098X MOVE THE RELATED TOTAL CHARGE
AMOUNT TO NCH_PROFNL_CMPNT_CHRG_AMT.

NOTE1: DURING THE VERSION H CONVERSION, THIS

```
 1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                  POSITIONS
          NAME                TYPE  LENGTH BEG   END                          CONTENTS
     ----------------------- ----  ------ --------   ------------------------------------------------
```

FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY
BUT THE DERIVATION RULE APPLIED TO THE OUTPATIENT

CLAIM WAS INCOMPLETE (I.E., REVENUE CODES 0972,
0973, 0974 AND 0979 WERE OMITTED FROM THE CALCU-
LATION).

SOURCE:
NCH QA PROCESS

112. CLAIM OUTPATIENT   PACK   6   544   549   EFFECTIVE WITH VERSION H, THE AMOUNT PAID BY THE
      BENEFICIARY INTERIM   BENEFICIARY THAT IS BEING APPLIED TO THE
      DEDUCTIBLE AMOUNT   DEDUCTIBLE, AS REPORTED ON THE OUTPATIENT CLAIM .

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
ZEROES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: INTRM_DDCTBL_AMT
SAS ALIAS: INTRMDED
STANDARD ALIAS: CLM_OP_BENE_INTRM_DDCTBL_AMT
TITLE ALIAS: INTRM_DDCTBL

SOURCE:
CWF

113. CLAIM OUTPATIENT PROVIDER   PACK   6   550   555   EFFECTIVE WITH VERSION H, THE AMOUNT PAID TO THE
      PAYMENT AMOUNT   PROVIDER FOR THE SERVICES REPORTED ON THE
                                               OUTPATIENT CLAIM .

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
ZEROES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: OP_PRVDR_PMT_AMT
SAS ALIAS: PRVDRPMT
STANDARD ALIAS: CLM_OP_PRVDR_PMT_AMT
TITLE ALIAS: OP_PRVDR_PMT

SOURCE:
NCH

```
114. CLAIM OUTPATIENT           PACK     6   556  561  EFFECTIVE WITH VERSION H, THE AMOUNT PAID TO THE
     BENEFICIARY PAYMENT AMOUNT                        BENEFICIARY FOR THE SERVICES REPORTED ON THE
                                                       OUTPATIENT CLAIM .

                                                       NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                       ZEROES IN THIS FIELD.

1                       FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
          NAME                 TYPE  LENGTH BEG   END                         CONTENTS
     ---------------------------  ----  ------ ---------  ----------------------------------------------------
                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: OP_BENE_PMT_AMT
                                                       SAS ALIAS: BENEPMT
                                                       STANDARD ALIAS: CLM_OP_BENE_PMT_AMT
                                                       TITLE ALIAS: OP_BENE_PMT


                                                       SOURCE:
                                                       CWF

115. NCH BLOOD PINTS FURNISHED   PACK     2   562  563  NUMBER OF WHOLE PINTS OF BLOOD FURNISHED TO THE
     QUANTITY                                           BENEFICIARY.

                                                       3 DIGITS SIGNED

                                                       DB2 ALIAS: NCH_BLOOD_PT_FRNSH
                                                       SAS ALIAS: BLDFRNSH
                                                       STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY
                                                       TITLE ALIAS: BLOOD_PINTS_FURNISHED

                                                       EDIT-RULES:
                                                       NUMERIC

                                                       DERIVATION:
                                                       DERIVED FROM:
                                                         CLM_VAL_CD
                                                         CLM_VAL_AMT

                                                       DERIVATION RULES:
```

```
                                              BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
                                              37 MOVE THE RELATED VALUE AMOUNT TO THE
                                              NCH_BLOOD_PT_FRNSH_QTY.

                                              COMMENT:
                                              PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                              CLM_BLOOD_PT_FRNSH_QTY.  ALSO FOR OUTPATIENT
                                              CLAIMS THIS FIELD WAS STORED IN A BLOOD
                                              TRAILER.  VERSION H ELIMINATED THE OUTPATIENT
                                              BLOOD TRAILER.

                                              SOURCE:
                                              NCH QA PROCESS

   116. NCH BLOOD PINTS REPLACED     PACK    2   564  565  NUMBER OF WHOLE PINTS OF BLOOD REPLACED.
        QUANTITY
                                              3 DIGITS SIGNED

                                              DB2 ALIAS: BLOOD_PT_RPLC_QTY
                                              SAS ALIAS: BLD_RPLC
                                              STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY
                                              TITLE ALIAS: BLOOD_PINTS_REPLACED

                                              EDIT-RULES:
                                              NUMERIC

                                              DERIVATION:
   1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                      POSITIONS
            NAME                 TYPE  LENGTH BEG  END                           CONTENTS
   ---------------------------- ---- ------ --------  ----------------------------------------------------
                                              DERIVED FROM:
                                                CLM_VAL_CD
                                                CLM_VAL_AMT

                                              DERIVATION RULES:
                                              BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
                                              39 MOVE THE RELATED VALUE AMOUNT TO THE
                                              NCH_BLOOD_PT_RPLC_QTY.

                                              COMMENT:
                                              PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                              CLM_BLOOD_PT_RPLC_QTY.  ALSO FOR OUTPATIENT
```

CLAIMS THIS FIELD WAS STORED IN A BLOOD
TRAILER. VERSION H ELIMINATED THE OUTPATIENT
BLOOD TRAILER.

SOURCE:
NCH QA PROCESS

117. NCH BLOOD PINTS NOT   PACK   2   566 567   NUMBER OF WHOLE PINTS OF BLOOD NOT REPLACED.
     REPLACED QUANTITY

3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_NRPLC_QTY
SAS ALIAS: BLDNRPLC
STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY
TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED

EDIT-RULES:
NUMERIC

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
SUBTRACT VALUE CODE 39 AMOUNT FROM VALUE CODE
37 AMOUNT AND MOVE THE RESULT TO
NCH_BLOOD_PT_NRPLC_QTY.

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_BLOOD_PT_NRPLC_QTY. ALSO FOR OUTPATIENT
CLAIMS THIS FIELD WAS STORED IN A BLOOD
TRAILER. VERSION H ELIMINATED THE OUTPATIENT
BLOOD TRAILER.

SOURCE:
NCH QA PROCESS

118. NCH BLOOD DEDUCTIBLE PINTS   PACK   2   568 569   THE QUANTITY OF BLOOD PINTS APPLIED (BLOOD
     QUANTITY   DEDUCTIBLE).

```
1                              FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                   POSITIONS
                    NAME                 TYPE  LENGTH BEG  END                         CONTENTS
        ------------------------------   ----  ------ ---------  -------------------------------------------------
                                                                 3 DIGITS SIGNED

                                                                 DB2 ALIAS: BLOOD_DDCTBL_QTY
                                                                 SAS ALIAS: BLDDEDPT
                                                                 STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY
                                                                 TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE

                                                                 EDIT-RULES:
                                                                 NUMERIC

                                                                 DERIVATION:
                                                                 DERIVED FROM:
                                                                   CLM_VAL_CD
                                                                   CLM_VAL_AMT

                                                                 DERIVATION RULES:
                                                                 BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
                                                                 38 MOVE THE RELATED VALUE AMOUNT TO THE
                                                                 NCH_BLOOD_DDCTBL_PT_QTY.

                                                                 COMMENT:
                                                                 PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                                 CLM_BLOOD_DDCTBL_PT_QTY.  ALSO FOR OUTPATIENT
                                                                 CLAIMS THIS FIELD WAS STORED IN A BLOOD
                                                                 TRAILER.  VERSION H ELIMINATED THE OUTPATIENT
                                                                 BLOOD TRAILER.


                                                                 SOURCE:
                                                                 NCH QA PROCESS

   119. CLAIM OUTPATIENT              CHAR      1   570  570  EFFECTIVE WITH VERSION H, THE CODE DERIVED
         TRANSACTION TYPE CODE                                AT CWF BASED ON TYPE OF BILL AND PROVIDER NUMBER
                                                              TO IDENTIFY THE OUTPATIENT TRANSACTION TYPE.

                                                              NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                              10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                              CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                              SPACES IN THIS FIELD.
```

```
                                          DB2 ALIAS: OP_TRANS_TYPE_CD
                                          SAS ALIAS: TRANTYPE
                                          STANDARD ALIAS: CLM_OP_TRANS_TYPE_CD
                                          TITLE ALIAS: OP_TRANS_TYPE

                                          CODES:
                                            REFER TO: CLM_OP_TRANS_TYPE_TB
                                                      IN THE CODES APPENDIX

                                          SOURCE:
                                          CWF

  120. CLAIM OUTPATIENT ESRD         CHAR     1   571  571  EFFECTIVE WITH VERSION H, THE CODE DENOTING THE
       METHOD OF REIMBURSEMENT                             METHOD OF REIMBURSEMENT SELECTED BY THE ESRD BENE
       CODE                                                FOR HOME DIALYSIS (I.E. WHETHER HOME SUPPLIES ARE
                                                           PURCHASED THROUGH A FACILITY OR FROM A SUPPLIER.)
1                         FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                            POSITIONS
              NAME                  TYPE  LENGTH BEG  END                         CONTENTS
       ---------------------------- ---- ------ -------- -------------------------------------------------

                                          NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                          10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                          CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                          SPACES IN THIS FIELD.

                                          DB2 ALIAS: ESRD_REIMBRSMT_CD
                                          SAS ALIAS: ESRDMTHD
                                          STANDARD ALIAS: CLM_OP_ESRD_MTHD_REIMBRSMT_CD
                                          TITLE ALIAS: ESRD_REIMBRSMT_MTHD

                                          CODES:
                                          0 = NOT ESRD
                                          1 = METHOD 1 - HOME SUPPLIES PURCHASED
                                              THROUGH A FACILITY
                                          2 = METHOD 2 - HOME SUPPLIES PURCHASED
                                              FROM A SUPPLIER.

                                          SOURCE:
                                          CWF

  121. FILLER                        CHAR    24   572  595
```

```
****   FI OUTPATIENT CLAIM TRAILER  GROUP    VAR             VARIABLE PORTION OF THE FISCAL INTERMEDIARY OUTPATIEN
       GROUP                                                 CLAIM RECORD FOR VERSION I OF THE NCH.


                                                            STANDARD ALIAS: FI_OP_CLM_TRLR_GRP


****   NCH EDIT GROUP                 GROUP    5             THE NUMBER OF CLAIM EDIT TRAILERS IS DETERMINED
                                                            BY THE CLAIM EDIT CODE COUNT.


                                                            OCCURS: UP TO 13 TIMES
                                                                    DEPENDING ON OP_NCH_EDIT_CD_CNT


                                                            STANDARD ALIAS: NCH_EDIT_GRP


122. NCH EDIT TRAILER INDICATOR   CHAR     1             EFFECTIVE WITH VERSION H, THE CODE INDICATING
     CODE                                                 THE PRESENCE OF AN NCH EDIT TRAILER.


                                                            NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                            WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                                            YEAR 1991).


                                                            DB2 ALIAS: EDIT_TRLR_IND_CD
                                                            SAS ALIAS: EDITIND
                                                            STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD


                                                            CODES:
                                                            E = EDIT CODE TRAILER PRESENT


                                                            SOURCE:
                                                            NCH QA PROCESS


123. NCH EDIT CODE                 CHAR     4             THE CODE ANNOTATED TO THE CLAIM INDICATING
                                                            THE CWFMQA EDITING RESULTS SO USERS WILL
                                                            BE AWARE OF DATA DEFICIENCIES.
1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                           POSITIONS
            NAME                  TYPE  LENGTH BEG  END                        CONTENTS
    ---------------------------  ----  ------ --------  ----------------------------------------------------

                                                            NOTE:  PRIOR TO VERSION H ONLY THE HIGHEST
                                                            PRIORITY CODE WAS STORED.  BEGINNING 11/98
                                                            UP TO 13 EDIT CODES MAY BE PRESENT.
```

```
                                                    COMMON ALIAS: QA_ERROR_CODE
                                                    DB2 ALIAS: NCH_EDIT_CD
                                                    SAS ALIAS: EDIT_CD
                                                    STANDARD ALIAS: NCH_EDIT_CD
                                                    TITLE ALIAS: QA_ERROR_CD

                                                    CODES:
                                                      REFER TO: NCH_EDIT_TB
                                                               IN THE CODES APPENDIX

                                                    SOURCE:
                                                    NCH QA EDIT PROCESS

 ****   NCH PATCH GROUP            GROUP    11       OCCURS: UP TO 30 TIMES
                                                            DEPENDING ON OP_NCH_PATCH_CD_I_CNT

                                                    STANDARD ALIAS: NCH_PATCH_GRP

 124. NCH PATCH TRAILER INDICATOR  CHAR     1        EFFECTIVE WITH VERSION H, THE CODE INDICATING
      CODE                                           THE PRESENCE OF AN NCH PATCH TRAILER.

                                                    NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                    WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                                    YEAR 1991).

                                                    DB2 ALIAS: PATCH_TRLR_IND_CD
                                                    SAS ALIAS: PATCHIND
                                                    STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD

                                                    CODES:
                                                    P = PATCH CODE TRAILER PRESENT

                                                    SOURCE:
                                                    NCH

 125. NCH PATCH CODE               CHAR     2        EFFECTIVE WITH VERSION H, THE CODE ANNOTATED
                                                    TO THE CLAIM INDICATING A PATCH WAS APPLIED
                                                    TO THE RECORD DURING AN NCH NEARLINE RECORD
                                                    CONVERSION AND/OR DURING CURRENT PROCESSING.

                                                    NOTE:  PRIOR TO VERSION H THIS FIELD WAS LOCATED
                                                    IN THE THIRD AND FOURTH OCCURRENCE OF THE
                                                    CLM_EDIT_CD.
```

```
                                              DB2 ALIAS: NCH_PATCH_CD
                                              SAS ALIAS: PATCHCD
                                              STANDARD ALIAS: NCH_PATCH_CD
                                              TITLE ALIAS: NCH_PATCH

                                              CODES:
                                                REFER TO: NCH_PATCH_TB
   1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                           POSITIONS
              NAME                 TYPE  LENGTH BEG  END                             CONTENTS
     ---------------------------- ---- ------ --------- ----------------------------------------------------
                                                                   IN THE CODES APPENDIX

                                                              SOURCE:
                                                              NCH

   126. NCH PATCH APPLIED DATE     NUM     8                   EFFECTIVE WITH VERSION H, THE DATE THE NCH PATCH
                                                              WAS APPLIED TO THE CLAIM.


                                                              8 DIGITS UNSIGNED

                                                              DB2 ALIAS: NCH_PATCH_APPLY_DT
                                                              SAS ALIAS: PATCHDT
                                                              STANDARD ALIAS: NCH_PATCH_APPLY_DT
                                                              TITLE ALIAS: NCH_PATCH_DT

                                                              EDIT-RULES:
                                                              YYYYMMDD

                                                              SOURCE:
                                                              NCH

   ****   MCO PERIOD GROUP        GROUP    37                 THE NUMBER OF MANAGED CARE ORGANIZATION (MCO)
                                                              PERIOD DATA TRAILERS PRESENT IS DETERMINED BY
                                                              THE CLAIM MCO PERIOD TRAILER COUNT.  THIS FIELD
                                                              REFLECTS THE TWO MOST CURRENT MCO PERIODS IN THE
                                                              CWF BENEFICIARY HISTORY RECORD.  IT MAY HAVE NO
                                                              CONNECTION TO THE SERVICES ON THE CLAIM.

                                                              OCCURS: UP TO 2 TIMES
                                                                      DEPENDING ON OP_MCO_PRD_CNT
```

                                                                STANDARD ALIAS: MCO_PRD_GRP

   127. NCH MCO TRAILER INDICATOR   CHAR   1   EFFECTIVE WITH VERSION H, THE CODE INDICATING
       CODE   THE PRESENCE OF A MANAGED CARE ORGANIZATION (MCO)
                                                                TRAILER.

                                                                NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                                10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                                CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                                SPACES IN THIS FIELD.

                                                                COBOL ALIAS: MCO_IND
                                                                DB2 ALIAS: MCO_TRLR_IND_CD
                                                                SAS ALIAS: MCOIND
                                                                STANDARD ALIAS: NCH_MCO_TRLR_IND_CD
                                                                TITLE ALIAS: MCO_INDICATOR

                                                                CODES:
                                                                M = MCO TRAILER PRESENT

                                                                SOURCE:
                                                                NCH QA PROCESS

   128. MCO CONTRACT NUMBER   CHAR   5   EFFECTIVE WITH VERSION H, THIS FIELD REPRESENTS
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                            POSITIONS
                NAME   TYPE   LENGTH BEG END   CONTENTS
      ------------------------------ ---- ------ --------- --
                                                                THE PLAN CONTRACT NUMBER OF THE MANAGED CARE
                                                                ORGANIZATION (MCO).

                                                                NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                                10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                                CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                                SPACES IN THIS FIELD.

                                                                DB2 ALIAS: MCO_CNTRCT_NUM
                                                                SAS ALIAS: MCONUM
                                                                STANDARD ALIAS: MCO_CNTRCT_NUM
                                                                TITLE ALIAS: MCO_NUM

                                                                SOURCE:
                                                                CWF

```
  129. MCO OPTION CODE            CHAR     1              EFFECTIVE WITH VERSION H, THE CODE INDICATING
                                                         MANAGED CARE ORGANIZATION (MCO) LOCK-IN
                                                         ENROLLMENT STATUS OF THE BENEFICIARY.

                                                         NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                         10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                         CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                         SPACES IN THIS FIELD.

                                                         DB2 ALIAS: MCO_OPTN_CD
                                                         SAS ALIAS: MCOOPTN
                                                         STANDARD ALIAS: MCO_OPTN_CD
                                                         TITLE ALIAS: MCO_OPTION_CD

                                                         CODES:
                                                         *****FOR LOCK-IN BENEFICIARIES****
                                                         A = HCFA TO PROCESS ALL PROVIDER BILLS
                                                         B = MCO TO PROCESS ONLY IN-PLAN
                                                         C = MCO TO PROCESS ALL PART A AND PART B BILLS

                                                         ***** FOR NON-LOCK-IN BENEFICIARIES*****
                                                         1 = HCFA TO PROCESS ALL PROVIDER BILLS
                                                         2 = MCO TO PROCESS ONLY IN-PLAN PART A AND
                                                             PART B BILLS

                                                         SOURCE:
                                                         CWF

  130. MCO PERIOD EFFECTIVE DATE   NUM      8             EFFECTIVE WITH VERSION H, THE DATE THE BENE-
                                                         FICIARY'S ENROLLMENT IN THE MANAGED CARE
                                                         ORGANIZATION (MCO) BECAME EFFECTIVE.

                                                         NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                         10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                         CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                         ZEROES IN THIS FIELD.

                                                         8 DIGITS UNSIGNED

                                                         DB2 ALIAS: MCO_PRD_EFCTV_DT
  1                   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                       POSITIONS
```

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            NAME              TYPE  LENGTH BEG  END                        CONTENTS
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                                                       SAS ALIAS: MCOEFFDT
                                                       STANDARD ALIAS: MCO_PRD_EFCTV_DT
                                                       TITLE ALIAS: MCO_PERIOD_EFF_DT

                                                       EDIT-RULES:
                                                       YYYYMMDD

                                                       SOURCE:
                                                       CWF

131. MCO PERIOD TERMINATION DATE  NUM    8             EFFECTIVE WITH VERSION H, THE DATE THE BENE-
                                                       FICIARY'S ENROLLMENT IN THE MANAGED CARE
                                                       ORGANIZATION (MCO) WAS TERMINATED.

                                                       NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                       ZEROES IN THIS FIELD.

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: MCO_PRD_TRMNTN_DT
                                                       SAS ALIAS: MCOTRMDT
                                                       STANDARD ALIAS: MCO_PRD_TRMNTN_DT
                                                       TITLE ALIAS: MCO_PERIOD_TERM_DT

                                                       EDIT-RULES:
                                                       YYYYMMDD

                                                       SOURCE:
                                                       CWF

132. MCO HEALTH PLANID NUMBER    CHAR   14             A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
                                                       FOR STORING THE HEALTH PLANID ASSOCIATED WITH
                                                       THE MANAGED CARE ORGANIZATION (MCO).  PRIOR TO
                                                       VERSION 'I' THIS FIELD WAS NAMED:
                                                       MCO_PAYERID_NUM.

                                                       DB2 ALIAS: MCO_PLANID_NUM
                                                       SAS ALIAS: MCOPLNID
                                                       STANDARD ALIAS: MCO_HLTH_PLANID_NUM
                                                       TITLE ALIAS: MCO_PLANID
```

```
                                              COMMENT:
                                              PRIOR TO VERSION I THIS FIELD WAS NAMED:
                                              MCO_PAYERID_NUM.

                                              SOURCE:
                                              CWF

 ****  CLAIM HEALTH PLANID GROUP    GROUP    16          THE NUMBER OF HEALTH PLANID DATA TRAILERS IS DETERMIN
                                                         BY THE CLAIM HEALTH PLANID TRAILER COUNT.  PRIOR
                                                         TO VERSION 'I' THIS FIELD WAS NAMED:
                                                         CLM_PAYERID_GRP.

                                                         OCCURS: UP TO 3 TIMES
1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                           POSITIONS
          NAME                    TYPE  LENGTH BEG  END                              CONTENTS
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                                                         DEPENDING ON OP_CLM_HLTH_PLANID_CNT

                                                         STANDARD ALIAS: CLM_HLTH_PLANID_GRP

 133. NCH HEALTH PLANID TRAILER   CHAR      1             A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
      INDICATOR CODE                                      FOR STORING THE CODE THAT INDICATES THE PRESENCE
                                                          OF A HEALTH PLANID TRAILER.  NOTE: PRIOR TO
                                                          VERSION 'I' THIS FIELD WAS NAMED:
                                                          NCH_PAYERID_TRLR_IND_CD.

                                                          DB2 ALIAS: PLANID_TRLR_CD
                                                          SAS ALIAS: PLANIDIN
                                                          STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD

                                                          CODES:
                                                          I = HEALTH PLANID TRAILER PRESENT

                                                          COMMENT:
                                                          PRIOR TO VERSION I THIS FIELD WAS NAMED:
                                                          NCH_PAYERID_TRLR_IND_CD.

                                                          SOURCE:
                                                          NCH

 134. CLAIM HEALTH PLANID CODE    CHAR      1             A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
```

```
                                                    FOR STORING THE CODE IDENTIFYING THE TYPE OF
                                                    HEALTH PLANID.  PRIOR TO VERSION 'I' THIS FIELD
                                                    WAS NAMED: CLM_PAYERID-CD

                                                    DB2 ALIAS: CLM_PLANID_CD
                                                    SAS ALIAS: PLANIDCD
                                                    STANDARD ALIAS: CLM_HLTH_PLANID_CD
                                                    TITLE ALIAS: PLANID_TYPE

                                                    CODES:
                                                    1 = MEDICARE SECONDARY PAYER
                                                    2 = MEDICAID
                                                    3 = MEDIGAP
                                                    4 = SUPPLEMENTAL INSURER
                                                    5 = MANAGED CARE ORGANIZATION

                                                    COMMENT:
                                                    PRIOR TO VERSION I THIS FIELD WAS NAMED:
                                                    CLM_PAYERID_CD.

                                                    SOURCE:
                                                    CWF

  135. CLAIM HEALTH PLANID NUMBER   CHAR    14       A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
                                                    FOR STORING THE HEALTH PLANID NUMBER.  PRIOR
                                                    TO VERSION 'I' THIS FIELD WAS NAMED:
                                                    CLM_PAYERID_NUM.

                                                    DB2 ALIAS: CLM_PLANID_NUM
                                                    SAS ALIAS: PLANID
                                                    STANDARD ALIAS: CLM_HLTH_PLANID_NUM
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
                NAME                 TYPE  LENGTH BEG  END                        CONTENTS
        ---------------------------- ---- ------ -------- --------------------------------------------------
                                                    TITLE ALIAS: PLANID

                                                    COMMENT:
                                                    PRIOR TO VERSION I THIS FIELD WAS NAMED:
                                                    CLM_PAYERID_NUM.

                                                    SOURCE:
                                                    CWF
```

```
****   CLAIM DEMONSTRATION          GROUP   18          THE NUMBER OF DEMONSTRATION IDENTIFICATION
       IDENTIFICATION GROUP                             TRAILERS PRESENT IS DETERMINED BY THE CLAIM
                                                        DEMONSTRATION IDENTIFICATION TRAILER COUNT.

                                                        OCCURS: UP TO 5 TIMES
                                                                DEPENDING ON OP_CLM_DEMO_ID_CNT

                                                        STANDARD ALIAS: CLM_DEMO_ID_GRP

136. NCH DEMONSTRATION TRAILER      CHAR    1           EFFECTIVE WITH VERSION H, THE CODE INDICATING
     INDICATOR CODE                                     THE PRESENCE OF A DEMO TRAILER.

                                                        NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                        WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                                        YEAR 1991).

                                                        COBOL ALIAS: DEMO_IND
                                                        DB2 ALIAS: DEMO_TRLR_IND_CD
                                                        SAS ALIAS: DEMOIND
                                                        STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD
                                                        TITLE ALIAS: DEMO_INDICATOR

                                                        CODES:
                                                        D = DEMO TRAILER PRESENT

                                                        SOURCE:
                                                        NCH

137. CLAIM DEMONSTRATION            CHAR    2           EFFECTIVE WITH VERSION H, THE NUMBER ASSIGNED
     IDENTIFICATION NUMBER                              TO IDENTIFY A DEMO.  THIS FIELD IS ALSO USED TO
                                                        DENOTE SPECIAL PROCESSING (A.K.A. SPECIAL PROCESSING
                                                        NUMBER, SPN).

                                                        NOTE: PRIOR TO VERSION H, DEMO ID WAS STORED IN THE
                                                        REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE, POSITIONS
                                                        3 AND 4.   DURING THE H CONVERSION, THIS FIELD WAS
                                                        POPULATED WITH DATA THROUGHOUT HISTORY (AS APPRO-
                                                        PRIATE EITHER BY MOVING ID ON VERSION G OR BY
                                                        DERIVING FROM SPECIFIC DEMO CRITERIA).

                                                        01 = NURSING HOME CASE-MIX AND QUALITY: NHCMQ
                                                             (RUGS) DEMO -- TESTING PPS FOR SNFS IN 6
                                                             STATES, USING A CASE-MIX CLASSIFICATION
```

```
                                        SYSTEM BASED ON RESIDENT CHARACTERISTICS AND
                                        ACTUAL RESOURCES USED. THE CLAIMS CARRY A
                                        RUGS INDICATOR AND ONE OR MORE REVENUE CENTER
                                        CODES IN THE 9,000 SERIES.
  1                 FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                   POSITIONS
           NAME                 TYPE  LENGTH BEG  END                      CONTENTS
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                                                      NOTE1: EFFECTIVE FOR SNF CLAIMS WITH NCH WEEKLY
                                                      PROCESS DATE AFTER 2/8/96 (AND SERVICE DATE AFTER
                                                      12/31/95) -- BEGINNING 4/97, DEMO ID '01' WAS
                                                      DERIVED IN NCH BASED ON PRESENCE OF RUGS PHASE #
                                                      '2','3' OR '4' ON INCOMING CLAIM; SINCE 7/97, CWF
                                                      HAS BEEN ADDING ID TO CLAIM.

                                                      NOTE2:  DURING THE VERSION H CONVERSION, DEMO ID
                                                      '01' WAS POPULATED BACK TO NCH WEEKLY PROCESS DATE
                                                      2/9/96 BASED ON THE RUGS PHASE INDICATOR (STORED
                                                      IN CLAIM EDIT GROUP, 3RD OCCURRENCE, 4TH POSITION,
                                                      IN VERSION G).

                                                      02 = NATIONAL HHA PROSPECTIVE PAYMENT DEMO --
                                                           TESTING PPS FOR HHAS IN 5 STATES, USING TWO
                                                           ALTERNATE METHODS OF PAYING HHAS: PER VISIT
                                                           BY TYPE OF HHA VISIT AND PER EPISODE OF HH
                                                           CARE.

                                                      NOTE1:  EFFECTIVE FOR HHA CLAIMS WITH NCH WEEKLY
                                                      PROCESS DATE AFTER 5/31/95 -- BEGINNING 4/97,
                                                      DEMO ID '02' WAS DERIVED IN NCH BASED ON HCFA/
                                                      CHPP-SUPPLIED LISTING OF PROVIDER # AND START/
                                                      STOP DATES OF PARTICIPANTS.

                                                      NOTE2:  DURING THE VERSION H CONVERSION, DEMO ID
                                                      '02' WAS POPULATED BACK TO NCH WEEKLY PROCESS
                                                      DATE 6/95 BASED ON THE CHPP CRITERIA.

                                                      03 = TELEMEDICINE DEMO -- TESTING COVERING TRADI-
                                                           TIONALLY NONCOVERED PHYSICIAN SERVICES FOR
                                                           MEDICAL CONSULTATION FURNISHED VIA TWO-WAY, INTE
                                                           ACTIVE VIDEO SYSTEMS (I.E. TELECONSULTATION)
                                                           IN 4 STATES.  THE CLAIMS CONTAIN LINE ITEMS
```

                                        WITH 'QQ' HCPCS CODE.

                                        NOTE1: EFFECTIVE FOR PHYSICIAN/SUPPLIER (NONDMERC)
                                        CLAIMS WITH NCH WEEKLY PROCESS DATE AFTER 12/31/96
                                        (AND SERVICE DATE AFTER 9/30/96) -- SINCE 7/97,
                                        CWF HAS BEEN ADDING DEMO ID '03' TO CLAIM.

                                        NOTE2: DURING VERSION H CONVERSION, DEMO ID '03'
                                        WAS POPULATED BACK TO NCH WEEKLY PROCESS DATE 1/97
                                        BASED ON THE PRESENCE OF 'QQ' HCPCS ON ONE OR MORE
                                        LINE ITEMS.

                                        04 = UNITED MINE WORKERS OF AMERICA (UMWA) MANAGED
                                             CARE DEMO -- TESTING RISK SHARING FOR PART A
                                             SERVICES, PAYING SPECIAL CAPITATION RATES FOR
                                             ALL UMWA BENEFICIARIES RESIDING IN 13 DESIG-
                                             NATED COUNTIES IN 3 STATES.   UNDER THE DEMO,
                                             UMWA WILL WAIVE THE 3-DAY QUALIFYING HOSPITAL
                                             STAY FOR A SNF ADMISSION.   THE CLAIMS CONTAIN
                                             TOB '18X','21X','28X' AND '51X'; CONDITION
                                             CODE = W0; CLAIM MCO PAID SWITCH = NOT '0';
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                            POSITIONS
           NAME   TYPE LENGTH BEG   END   CONTENTS
    ---------------------------   ---- ------ -------- --
                                             AND MCO CONTRACT # = '90091'.

                                        NOTE: INITIALLY SCHEDULED TO BE IMPLEMENTED FOR
                                        ALL SNF CLAIMS FOR ADMISSION OR SERVICES ON
                                        1/1/97 OR LATER, CWF DID NOT TRANSMIT ANY DEMO
                                        ID '04' ANNOTATED CLAIMS UNTIL ON OR ABOUT 2/98.

                                        05 = MEDICARE CHOICES (MCO ENCOUNTER DATA) DEMO --
                                             TESTING EXPANDING THE TYPE OF MANAGED CARE
                                             PLANS AVAILABLE AND DIFFERENT PAYMENT METHODS
                                             AT 16 MCOS IN 9 STATES.   THE CLAIMS CONTAIN
                                             ONE OF THE SPECIFIC MCO PLAN CONTRACT #
                                             ASSIGNED TO THE CHOICES DEMO SITE.

                                        NOTE1: EFFECTIVE FOR ALL CLAIM TYPES WITH NCH
                                        WEEKLY PROCESS DATE AFTER 7/31/97 -- CWF ADDS
                                        DEMO ID '05' TO CLAIM BASED ON THE PRESENCES OF
                                        THE MCO PLAN CONTRACT #.

NOTE2: DURING THE VERSION H CONVERSION, DEMO ID
'05' WAS POPULATED BACK TO NCH WEEKLY PROCESS
DATE 8/97 BASED ON THE PRESENCE OF THE CHOICES
INDICATOR (STORED AS AN ALPHA CHARACTER CROSS-
WALKED FROM MCO PLAN CONTRACT # IN THE CLAIM
EDIT GROUP, 4TH OCCURRENCE, 2ND POSITION, IN
VERSION 'G').

06 = CORONARY ARTERY BYPASS GRAFT (CABG) DEMO --
     TESTING BUNDLED PAYMENT (ALL-INCLUSIVE GLOBAL
     PRICING) FOR HOSPITAL + PHYSICIAN SERVICES
     RELATED TO CABG SURGERY IN 7 HOSPITALS IN 7
     STATES. THE INPATIENT CLAIMS CONTAIN A DRG
     '106' OR '107'.

NOTE1: EFFECTIVE FOR INPATIENT CLAIMS AND
PHYSICIAN/SUPPLIER CLAIMS WITH CLAIM EDIT DATE
NO EARLIER THAN 6/1/91 (NOT ALL CABG SITES
STARTED AT THE SAME TIME) -- ON 5/1/97, CWF
STARTED TRANSMITTING DEMO ID '06' ON THE CLAIM.
THE FI ADDS THE ID TO THE CLAIM BASED ON THE
PRESENCE OF DRG '106' OR '107' FROM SPECIFIC
PROVIDERS FOR SPECIFIED TIME PERIODS; THE
CARRIER ADDS THE ID TO THE CLAIM BASED ON
RECEIVING 'DAILY CENSUS LIST' FROM PARTI-
CIPATING HOSPITALS. DEMO ID '06' WILL END
ONCE DEMO ID '07' IS IMPLEMENTED.

NOTE2: DURING THE VERSION H CONVERSION, ANY
CLAIMS WHERE MEDICARE IS THE PRIMARY PAYER
THAT WERE NOT ALREADY IDENTIFIED AS DEMO ID
'06' (STORED IN THE REDEFINED CLAIM EDIT
GROUP, 4TH OCCURRENCE, POSITIONS 3 AND 4,
VERSION G) WERE ANNOTATED BASED ON THE FOLLOW-
ING CRITERIA: INPATIENT - PRESENCE OF DRG '106'
OR '107' AND A PROVIDER NUMBER=220897, 150897,
380897,450897,110082,230156 OR 360085 FOR

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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                                        POSITIONS
             NAME                TYPE  LENGTH BEG  END                         CONTENTS
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                                                           SPECIFIED SERVICE DATES; NONINSTITUTIONAL -
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PRESENCE OF HCPCS MODIFIER (INITIAL AND/OR
SECOND) = 'Q2' AND A CARRIER NUMBER =00700/31143
00630,01380,00900,01040/00511,00710,00623, OR
13630 FOR SPECIFIED SERVICE DATES.

07 = PARTICIPATING CENTERS OF EXCELLENCE (PCOE)
     DEMO -- TESTING A NEGOTIATED ALL-INCLUSIVE
     PRICING ARRANGEMENT (BUNDLED RATES) FOR HIGH-
     COST ACUTE CARE CARDIOVASCULAR AND ORTHOPEDIC
     PROCEDURES PERFORMED IN 60-100 PREMIER FACILI-
     TIES IN THE CHICAGO AND SAN FRANCISCO REGIONS
     OR BY CURRENT CABG PROVIDERS. THE INPATIENT
     CLAIMS WILL CONTAIN A DRG '104','105','106',
     '107','112','124','125','209',OR '471'; THE
     RELATED PHYSICIAN/SUPPLIER CLAIMS WILL CONTAIN
     THE CLAIM PAYMENT DENIAL REASON CODE = 'D'.

NOTE: THE DEMO IS ON HOLD. THE FI AND CARRIER WILL
ADD DEMO ID '07' TO CLAIM.

08 = PROVIDER PARTNERSHIP DEMO -- TESTING PER-CASE
     PAYMENT APPROACHES FOR ACUTE INPATIENT
     HOSPITALIZATIONS, MAKING A LUMP-SUM PAYMENT
     (COMBINING THE NORMAL PART A PPS PAYMENT WITH
     THE PART B ALLOWED CHARGES INTO A SINGLE FEE
     SCHEDULE) TO A PHYSICIAN/HOSPITAL ORGANIZATION
     FOR ALL PART A AND PART B SERVICES ASSOCIATED
     WITH A HOSPITAL ADMISSION. FROM 3 TO 6 HOSPITAL
     IN THE NORTHEAST AND MID-ATLANTIC REGIONS MAY
     PARTICIPATE IN THE DEMO.

NOTE: THE DEMO IS ON HOLD. THE FI AND CARRIER WILL
ADD DEMO ID '08' TO CLAIM.

15 = ESRD MANAGED CARE (MCO ENCOUNTER DATA) --
     TESTING OPEN ENROLLMENT OF ESRD BENEFICIARIES
     AND CAPITATION RATES ADJUSTED FOR PATIENT
     TREATMENT NEEDS AT 3 MCOS IN 3 STATES. THE
     CLAIMS CONTAIN ONE OF THE SPECIFIC MCO PLAN
     CONTRACT # ASSIGNED TO THE ESRD DEMO SITE.

NOTE: EFFECTIVE 10/1/97 (BUT NOT ACTUALLY IMPLE-
MENTED AT A SITE UNTIL 1/1/98) FOR ALL CLAIM
TYPES -- THE FI AND CARRIER ADD DEMO ID '15' TO

```
                                        CLAIM BASED ON THE PRESENCE OF THE MCO PLAN
                                        CONTRACT #.

                                        30 = LUNG VOLUME REDUCTION SURGERY (LVRS) OR
                                             NATIONAL EMPHYSEMA TREATMENT TRIAL (NETT)
                                             CLINICAL STUDY -- EVALUATING THE EFFECTIVE-
                                             NESS OF LVRS AND MAXIMUM MEDICAL THERAPY (IN-
                                             CLUDING PULMONARY REHAB) FOR MEDICARE BENE-
                                             FICIARIES IN LAST STAGES OF EMPHYSEMA AT 18
                                             HOSPITALS NATIONALLY, IN COLLABORATION WITH
                                             NIH.
1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
            NAME                 TYPE  LENGTH BEG  END                           CONTENTS
   ----------------------------  ----  ------ --------  -------------------------------------------------
                                                        NOTE:  EFFECTIVE FOR ALL CLAIM TYPES (EXCEPT DMERC)
                                                        WITH NCH WEEKLY PROCESS DATE AFTER 2/27/98 (AND
                                                        SERVICE DATE AFTER 10/31/97) -- THE FI ADDS DEMO ID
                                                        '30' BASED ON THE PRESENCE OF A CONDITION CODE = EY;
                                                        THE PARTICIPATING PHYSICIAN (NOT THE CARRIER) ADDS
                                                        ID TO THE NONINSTITUTIONAL CLAIM.  DUE TO THE SEN-
                                                        SITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE
                                                        TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE
                                                        CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO
                                                        HCFA BUT NOT STORED IN THE NEARLINE FILE (ACCESS
                                                        IS RESTRICTED TO STUDY EVALUATORS ONLY).

                                                        31 = VA PRICING SPECIAL PROCESSING (SPN) -- NOT REALL
                                                             A DEMO BUT SPECIAL REQUEST FROM VA DUE TO
                                                             COURT SETTLEMENT; NOT MEDICARE SERVICES BUT
                                                             VA INPATIENT AND PHYSICIAN SERVICES SUBMITTED
                                                             TO FI 00400 AND CARRIER 00900 TO OBTAIN
                                                             MEDICARE PRICING -- CWF WILL PROCESS VA
                                                             CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL
                                                             NOT TRANSMIT TO HCFA (NOT IN NEARLINE FILE).

                                                        37 = MEDICARE COORDINATED CARE DEMONSTRATION -- TO TE
                                                             WHETHER COORDINATED CARE SERVICES FURNISHED TO
                                                             CERTAIN BENEFICIARIES IMPROVE OUTCOMES OF CARE
                                                             AND REDUCE MEDICARE EXPENDITURES UNDER PART A AN
                                                             PART B.  THERE WILL BE AT LEAST 9 COORDINATED
                                                             CARE ENTITIES (CCES).  THE SELECTED ENTITIES WIL
```

```
                                                    BE ASSIGNED A PROVIDER NUMBER SPECIFICALLY FOR T
                                                    DEMONSTRATION SERVICES.

                                             NOTE:  THE DEMO IS ON HOLD.  THE FI AND CARRIER WILL
                                             ADD DEMO ID '37' TO CLAIM.

                                             38 = PHYSICIAN ENCOUNTER CLAIMS - THE PURPOSE OF THIS
                                                    DEMO ID IS TO IDENTIFY THE PHYSICIAN ENCOUNTER
                                                    CLAIMS BEING PROCESSED AT THE HCFA DATA CENTER (
                                                    THIS NUMBER WILL HELP EDS IN MAKING THE CLAIM GO
                                                    THROUGH THE APPROPRIATE PROCESSING LOGIC, WHICH
                                                    DIFFERS FROM THAT FOR FEE-FOR-SERVICE.  **NOT
                                                    IN NCH -- AVAILABLE IN NMUD.**

                                             NOTE: EFFECTIVE OCTOBER, 2000. DEMO IDS WILL NOT BE
                                             ASSIGNED TO INPATIENT AND OUTPATIENT ENCOUNTER CLAIMS

                                             39 = CENTRALIZED BILLING OF FLU AND PPV CLAIMS -- THE
                                                    PURPOSE OF THIS DEMO IS TO FACILITATE THE PROCES
                                                    CARRIER, TRAILBLAZERS, PAYING FLU AND PPV CLAIMS
                                                    BASED ON PAYMENT LOCALITIES.  PROVIDERS WILL BE
                                                    GIVING THE SHOTS THROUGHOUT THE COUNTRY AND TRAN
                                                    MITTING THE CLAIMS TO TRAILBLAZERS FOR PROCESSIN

                                             NOTE: EFFECTIVE OCTOBER, 2000 FOR CARRIER CLAIMS.

                                             DB2 ALIAS: CLM_DEMO_ID_NUM
                                             SAS ALIAS: DEMONUM
  1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                         POSITIONS
             NAME                TYPE  LENGTH BEG  END                            CONTENTS
   --------------------------   ----  ------ --------    ------------------------------------------------
                                             STANDARD ALIAS: CLM_DEMO_ID_NUM
                                             TITLE ALIAS: DEMO_ID

                                             SOURCE:
                                             CWF

   138. CLAIM DEMONSTRATION       CHAR    15                EFFECTIVE WITH VERSION H, THE TEXT FIELD THAT
         INFORMATION TEXT                                   CONTAINS RELATED DEMO INFORMATION.  FOR EXAMPLE,
                                                            A CLAIM INVOLVING A CHOICES DEMO ID '05' WOULD
                                                            CONTAIN THE MCO PLAN CONTRACT NUMBER IN THE FIRST
                                                            FIVE POSITIONS OF THIS TEXT FIELD.
```

NOTE: DURING THE VERSION H CONVERSION THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT
HISTORY.

DB2 ALIAS: CLM_DEMO_INFO_TXT
SAS ALIAS: DEMOTXT
STANDARD ALIAS: CLM_DEMO_INFO_TXT
TITLE ALIAS: DEMO_INFO

DERIVATION:
DERIVATION RULES:
DEMO ID = 01 (RUGS) -- THE TEXT FIELD WILL CONTAIN
A 2, 3 OR 4 TO DENOTE THE RUGS PHASE. IF RUGS PHASE
IS BLANK OR NOT ONE OF THE ABOVE THE TEXT FIELD
WILL REFLECT 'INVALID'. NOTE: IN VERSION 'G', RUGS
PHASE WAS STORED IN REDEFINED CLAIM EDIT GROUP,
3RD OCCURRENCE, 4TH POSITION.

DEMO ID = 02 (HOME HEALTH DEMO) -- THE TEXT FIELD
WILL CONTAIN PROV#. WHEN DEMO NUMBER NOT EQUAL TO
02 THEN TEXT WILL REFLECT 'INVALID'.

DEMO ID = 03 (TELEMEDICINE DEMO) -- TEXT FIELD WILL
CONTAIN THE HCPCS CODE. IF THE REQUIRED HCPCS IS
NOT SHOWN THEN THE TEXT FIELD WILL REFLECT
'INVALID'.

DEMO ID = 04 (UMWA) -- TEXT FIELD WILL CONTAIN
W0 DENOTING THAT CONDITION CODE W0 WAS PRESENT.
IF CONDITION CODE W0 NOT PRESENT THEN THE TEXT
FIELD WILL REFLECT 'INVALID'.

DEMO ID = 05 (CHOICES) -- THE TEXT FIELD WILL CON-
TAIN THE CHOICES PLAN NUMBER, IF BOTH OF THE FOLLOW-
ING CONDITIONS ARE MET: (1) CHOICES PLAN NUMBER
PRESENT AND PPS OR INPATIENT CLAIM SHOWS THAT 1ST
3 POSITIONS OF PROVIDER NUMBER AS '210' AND THE
ADMISSION DATE IS WITHIN HMO EFFECTIVE/TERMINATION
DATE; OR NON-PPS CLAIM AND THE FROM DATE IS WITHIN
HMO EFFECTIVE/TERMINATION DATE AND (2) CHOICES
PLAN NUMBER MATCHES THE HMO PLAN NUMBER. IF
EITHER CONDITION IS NOT MET THE TEXT FIELD WILL

```
                                                     REFLECT 'INVALID CHOICES PLAN NUMBER'.  WHEN
     1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
              NAME                 TYPE  LENGTH BEG  END                            CONTENTS
     ----------------------------- ----  ------ --------- --------------------------------------------------
                                                     CHOICES PLAN NUMBER NOT PRESENT, TEXT WILL RE-
                                                     FLECT 'INVALID'.

                                                     NOTE:  IN VERSION 'G', A VALID CHOICES PLAN ID IS
                                                     STORED AS ALPHA CHARACTER IN REDEFINED CLAIM
                                                     EDIT GROUP, 4TH OCCURRENCE, 2ND POSITION.  IF
                                                     INVALID, CHOICES INDICATOR 'ZZ' DISPLAYED.

                                                     DEMO ID = 15 (ESRD MANAGED CARE) -- TEXT FIELD
                                                     WILL CONTAIN THE ESRD/MCO PLAN NUMBER.  IF ESRD/
                                                     MCO PLAN NUMBER NOT PRESENT THE FIELD WILL
                                                     REFLECT 'INVALID'.

                                                     DEMO ID = 38 (PHYSICIAN ENCOUNTER CLAIMS) --
                                                     TEXT FIELD WILL CONTAIN THE MCO PLAN NUMBER.
                                                     WHEN MCO PLAN NUMBER NOT PRESENT THE FIELD WILL
                                                     REFLECT 'INVALID'.


                                                     SOURCE:
                                                     CWF

      ****   CLAIM DIAGNOSIS GROUP        GROUP    7       THE NUMBER OF CLAIM DIAGNOSIS TRAILERS IS
                                                     DETERMINED BY THE CLAIM DIAGNOSIS CODE
                                                     COUNT.  THE PRINCIPAL DIAGNOSIS IS THE FIRST OCCURREN
                                                     THE 'E' CODE (ICD-9-CM CODE FOR THE EXTERNAL CAUSE
                                                     OF AN INJURY, POISONING, OR ADVERSE AFFECT) IS
                                                     STORED AS THE LAST OCCURRENCE.
                                                     THE PRINCIPAL DIAGNOSIS AND THE 'E' CODE ARE ALSO
                                                     STORED (REDUNDANTLY) IN THE FIXED PORTION
                                                     OF THE RECORD.

                                                     NOTE:
                                                     PRIOR TO VERSION H THIS GROUP WAS NAMED:
                                                     CLM_OTHR_DGNS_GRP AND DID NOT CONTAIN THE
                                                     CLM_PRNCPAL_DGNS_CD.

                                                     OCCURS: UP TO 10 TIMES
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                                                    DEPENDING ON OP_CLM_DGNS_CD_CNT

                                                    STANDARD ALIAS: CLM_DGNS_GRP

  139. NCH DIAGNOSIS TRAILER          CHAR      1   EFFECTIVE WITH VERSION H, THE CODE INDICATING
       INDICATOR CODE                                 THE PRESENCE OF A DIAGNOSIS TRAILER.

                                                    NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                    WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                                    YEAR 1991).

                                                    DB2 ALIAS: DGNS_TRLR_IND_CD
                                                    SAS ALIAS: DGNSIND
                                                    STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD

                                                    CODES:
                                                    Y = DIAGNOSIS CODE TRAILER PRESENT
```

```
1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
            NAME                TYPE  LENGTH BEG   END                              CONTENTS
  ---------------------------- ---- ------ --------- ------------------------------------------------
                                                    SOURCE:
                                                    NCH

  140. CLAIM DIAGNOSIS CODE          CHAR      5    THE ICD-9-CM BASED CODE IDENTIFYING THE
                                                    BENEFICIARY'S PRINCIPAL OR OTHER DIAGNOSIS
                                                    (INCLUDING E CODE).

                                                    NOTE:
                                                    PRIOR TO VERSION H, THE PRINCIPAL DIAGNOSIS
                                                    CODE WAS NOT STORED WITH THE 'OTHER' DIAGNOSIS
                                                    CODES.  DURING THE VERSION H CONVERSION THE
                                                    CLM_PRNCPAL_DGNS_CD WAS ADDED AS THE FIRST
                                                    OCCURRENCE.

                                                    DB2 ALIAS: CLM_DGNS_CD
                                                    SAS ALIAS: DGNS_CD
                                                    STANDARD ALIAS: CLM_DGNS_CD
                                                    TITLE ALIAS: DIAGNOSIS

                                                    EDIT-RULES:
                                                    ICD-9-CM
```

```
                                                      COMMENT:
                                                      PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                                      CLM_OTHR_DGNS_CD.

     141. FILLER                       CHAR      1

  ****   CLAIM PROCEDURE GROUP         GROUP    16         THE NUMBER OF CLAIM PROCEDURE TRAILERS IS DETERMINED
                                                      BY THE CLAIM PROCEDURE CODE COUNT.  PRIOR TO 10/93
                                                      UP TO 10 OCCURRENCES COULD BE REPORTED ON AN
                                                      INSTITUTIONAL CLAIM.  BEGINNING 10/93, UP TO SIX
                                                      OCCURRENCES (ONE PRINCIPAL; FIVE OTHERS) MAY BE
                                                      REPORTED.

                                                      OCCURS: UP TO 6 TIMES
                                                              DEPENDING ON OP_CLM_PRCDR_CD_CNT

                                                      STANDARD ALIAS: CLM_PRCDR_GRP

     142. NCH PROCEDURE TRAILER        CHAR      1         EFFECTIVE WITH VERSION H, THE CODE INDICATING THE PRE
          INDICATOR CODE                                   OF A PROCEDURE TRAILER.

                                                      NOTE:  DURING THE VERSION H CONVERSION THIS FIELD WAS
                                                      POPULATED THROUGHOUT HISTORY (BACK TO SERVICE YEAR 19

                                                      DB2 ALIAS: PRCDR_TRLR_IND_CD
                                                      SAS ALIAS: PRCDRIND
                                                      STANDARD ALIAS: NCH_PRCDR_TRLR_IND_CD

                                                      CODES:
                                                      Z = PROCEDURE CODE TRAILER PRESENT

                                                      SOURCE:
                                                      NCH
```

```
 1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                            POSITIONS
            NAME                    TYPE   LENGTH BEG   END                          CONTENTS
    ---------------------------- ---- ------ --------- -------------------------------------------------------
     143. CLAIM PROCEDURE CODE        CHAR      4         THE ICD-9-CM CODE THAT INDICATES THE PRINCIPAL OR OTH
                                                      PROCEDURE PERFORMED DURING THE PERIOD COVERED BY THE
                                                      INSTITUTIONAL CLAIM.
```

```
                                          DB2 ALIAS: CLM_PRCDR_CD
                                          SAS ALIAS: PRCDR_CD
                                          STANDARD ALIAS: CLM_PRCDR_CD
                                          TITLE ALIAS: PROCEDURE_CODE


                                          EDIT-RULES:
                                          ICD-9-CM


                                          SOURCE:
                                          CWF

   144.  FILLER                CHAR    3

   145.  CLAIM PROCEDURE PERFORMED  NUM    8    ON AN INSTITUTIONAL CLAIM, THE DATE ON WHICH
         DATE                                   THE PRINCIPAL OR OTHER PROCEDURE WAS PERFORMED.

                                          8 DIGITS UNSIGNED

                                          DB2 ALIAS: CLM_PRCDR_PRFRM_DT
                                          SAS ALIAS: PRCDR_DT
                                          STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
                                          TITLE ALIAS: PROCEDURE_DATE


                                          EDIT-RULES:
                                          YYYYMMDD


                                          SOURCE:
                                          CWF

  ****  CLAIM RELATED CONDITION    GROUP   3    THE NUMBER OF CLAIM RELATED CONDITION TRAILERS IS
        GROUP                                   DETERMINED BY THE CLAIM RELATED CONDITION CODE COUNT.
                                          EFFECTIVE 10/93, UP TO 30 OCCURRENCES CAN BE REPORTED
                                          ON AN INSTITUTIONAL CLAIM.  PRIOR TO 10/93, UP TO
                                          10 OCCURRENCES COULD BE REPORTED.


                                          OCCURS: UP TO 30 TIMES
                                                  DEPENDING ON OP_CLM_RLT_COND_CD_CNT

                                          STANDARD ALIAS: CLM_RLT_COND_GRP

   146.  NCH CONDITION TRAILER    CHAR    1    EFFECTIVE WITH VERSION H, THE CODE INDICATING
         INDICATOR CODE                        THE PRESENCE OF A CONDITION CODE TRAILER.

                                          NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
```

                                                       WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                                       YEAR 1991).

                                                       DB2 ALIAS: COND_TRLR_IND_CD
                                                       SAS ALIAS: CONDIND
                                                       STANDARD ALIAS: NCH_COND_TRLR_IND_CD

                                                       CODES:
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                        POSITIONS
            NAME   TYPE   LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ -------- --
                                                       C = CONDITION CODE TRAILER PRESENT

                                                       SOURCE:
                                                       NCH

  147. CLAIM RELATED CONDITION   CHAR   2   THE CODE THAT INDICATES A CONDITION RELATING TO
       CODE   AN INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER
                                                         PROCESSING.

                                                       DB2 ALIAS: CLM_RLT_COND_CD
                                                       SAS ALIAS: RLT_COND
                                                       STANDARD ALIAS: CLM_RLT_COND_CD
                                                       SYSTEM ALIAS: LTCOND
                                                       TITLE ALIAS: RELATED_CONDITION_CD

                                                       CODES:
                                                       01 THRU 16 = INSURANCE RELATED
                                                       17 THRU 30 = SPECIAL CONDITION
                                                       31 THRU 35 = STUDENT STATUS CODES WHICH ARE REQUIRED
                                                                      WHEN A PATIENT IS A DEPENDENT CHILD
                                                                      OVER 18 YEARS OLD
                                                       36 THRU 45 = ACCOMMODATION
                                                       46 THRU 54 = CHAMPUS INFORMATION
                                                       55 THRU 59 = SKILLED NURSING FACILITY
                                                       60 THRU 70 = PROSPECTIVE PAYMENT
                                                       71 THRU 99 = RENAL DIALYSIS SETTING
                                                       A0 THRU B9 = SPECIAL PROGRAM CODES
                                                       C0 THRU C9 = PRO APPROVAL SERVICES
                                                       D0 THRU W0 = CHANGE CONDITIONS

                                                       CODES:

```
                                              REFER TO: CLM_RLT_COND_TB
                                                        IN THE CODES APPENDIX

                                              SOURCE:
                                              CWF

 ****   CLAIM RELATED OCCURRENCE    GROUP    11          THE NUMBER OF CLAIM RELATED OCCURRENCE TRAILERS IS
        GROUP                                            DETERMINED BY THE CLAIM RELATED OCCURRENCE CODE COUNT
                                                         EFFECTIVE 10/93, UP TO 30 OCCURRENCES CAN BE REPORTED
                                                         ON AN INSTITUTIONAL CLAIM.  PRIOR TO 10/93, UP TO 10
                                                         OCCURRENCES COULD BE REPORTED.

                                              OCCURS: UP TO 30 TIMES
                                                      DEPENDING ON OP_CLM_RLT_OCRNC_CD_CNT

                                              STANDARD ALIAS: CLM_RLT_OCRNC_GRP

 148. NCH OCCURRENCE TRAILER        CHAR     1           EFFECTIVE WITH VERSION H, THE CODE INDICATING
       INDICATOR CODE                                    THE PRESENCE OF A OCCURRENCE CODE TRAILER.

                                              NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                              WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                              YEAR 1991).

                                              DB2 ALIAS: OCRNC_TRLR_IND_CD
 1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                      POSITIONS
            NAME                TYPE  LENGTH BEG  END                       CONTENTS
     --------------------------  ----  ------ ---------  ----------------------------------------------------
                                              SAS ALIAS: OCRNCIND
                                              STANDARD ALIAS: NCH_OCRNC_TRLR_IND_CD

                                              CODES:
                                              O = OCCURRENCE CODE TRAILER PRESENT

                                              SOURCE:
                                              NCH

 149. CLAIM RELATED OCCURRENCE     CHAR     2           THE CODE THAT IDENTIFIES A SIGNIFICANT EVENT
       CODE                                             RELATING TO AN INSTITUTIONAL CLAIM THAT MAY
                                                        AFFECT PAYER PROCESSING.   THESE CODES ARE
                                                        CLAIM-RELATED OCCURRENCES THAT ARE RELATED
                                                        TO A SPECIFIC DATE.
```

```
                                              DB2 ALIAS: CLM_RLT_OCRNC_CD
                                              SAS ALIAS: OCRNC_CD
                                              STANDARD ALIAS: CLM_RLT_OCRNC_CD
                                              SYSTEM ALIAS: LTOCRNC
                                              TITLE ALIAS: OCCURRENCE_CD

                                              CODES:
                                              01 THRU 09 = ACCIDENT
                                              10 THRU 19 = MEDICAL CONDITION
                                              20 THRU 39 = INSURANCE RELATED
                                              40 THRU 69 = SERVICE RELATED
                                              A1-A3 = MISCELLANEOUS

                                              CODES:
                                                REFER TO: CLM_RLT_OCRNC_TB
                                                          IN THE CODES APPENDIX

                                              SOURCE:
                                              CWF
```

150. CLAIM RELATED OCCURRENCE   NUM   8   THE DATE ASSOCIATED WITH A SIGNIFICANT EVENT
     DATE   RELATED TO AN INSTITUTIONAL CLAIM THAT MAY
                                                     AFFECT PAYER PROCESSING.

                                              8 DIGITS UNSIGNED

                                              DB2 ALIAS: CLM_RLT_OCRNC_DT
                                              SAS ALIAS: OCRNCDT
                                              STANDARD ALIAS: CLM_RLT_OCRNC_DT
                                              TITLE ALIAS: RLT_OCRNC_DT

                                              EDIT-RULES:
                                              YYYYMMDD

                                              SOURCE:
                                              CWF

 ****   CLAIM OCCURRENCE SPAN GROUP   GROUP   19   THE NUMBER OF CLAIM OCCURRENCE SPAN TRAILERS IS
                                                     DETERMINED BY THE CLAIM OCCURRENCE SPAN CODE COUNT.
                                                     UP TO 10 OCCURRENCES MAY BE REPORTED ON AN
                                                     INSTITUTIONAL CLAIM.
 1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

```
                                   POSITIONS
          NAME                TYPE  LENGTH BEG  END                        CONTENTS
-----------------------------  ----  ------ ---------  --------------------------------------------------
                                                      OCCURS: UP TO 10 TIMES
                                                              DEPENDING ON OP_CLM_OCRNC_SPAN_CD_CNT

                                                      STANDARD ALIAS: CLM_OCRNC_SPAN_GRP

151. NCH SPAN TRAILER INDICATOR   CHAR     1          EFFECTIVE WITH VERSION H, THE CODE INDICATING
     CODE                                             THE PRESENCE OF A SPAN CODE TRAILER.

                                                      NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                                      WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                                      YEAR 1991).

                                                      DB2 ALIAS: SPAN_TRLR_IND_CD
                                                      SAS ALIAS: SPANIND
                                                      STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD

                                                      CODES:
                                                      S = SPAN CODE TRAILER PRESENT

                                                      SOURCE:
                                                      NCH

152. CLAIM OCCURRENCE SPAN CODE   CHAR     2          THE CODE THAT IDENTIFIES A SIGNIFICANT EVENT
                                                      RELATING TO AN INSTITUTIONAL CLAIM THAT MAY
                                                      AFFECT PAYER PROCESSING. THESE CODES ARE
                                                      CLAIM-RELATED OCCURRENCES THAT ARE RELATED
                                                      TO A TIME PERIOD (SPAN OF DATES).

                                                      DB2 ALIAS: CLM_OCRNC_SPAN_CD
                                                      SAS ALIAS: SPAN_CD
                                                      STANDARD ALIAS: CLM_OCRNC_SPAN_CD
                                                      SYSTEM ALIAS: LTSPAN
                                                      TITLE ALIAS: SPAN_CD

                                                      CODES:
                                                        REFER TO: CLM_OCRNC_SPAN_TB
                                                                  IN THE CODES APPENDIX

                                                      SOURCE:
                                                      CWF
```

153. CLAIM OCCURRENCE SPAN FROM   NUM   8   THE FROM DATE OF A PERIOD ASSOCIATED WITH
     DATE   AN OCCURRENCE OF A SPECIFIC EVENT RELATING TO
                                                                AN INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER
                                                                PROCESSING.

                                                                8 DIGITS UNSIGNED

                                                                DB2 ALIAS: OCRNC_SPAN_FROM_DT
                                                                SAS ALIAS: SPANFROM
                                                                STANDARD ALIAS: CLM_OCRNC_SPAN_FROM_DT
                                                                TITLE ALIAS: SPAN_FROM_DT

                                                                EDIT-RULES:
                                                                YYYYMMDD
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                              POSITIONS
              NAME   TYPE   LENGTH BEG END   CONTENTS
     ---------------------------   ----   ------ --------   --

                                                                SOURCE:
                                                                CWF

154. CLAIM OCCURRENCE SPAN   NUM   8   THE THRU DATE OF A PERIOD ASSOCIATED WITH AN
     THROUGH DATE   OCCURRENCE OF A SPECIFIC EVENT RELATING TO AN
                                                                INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER
                                                                PROCESSING.

                                                                8 DIGITS UNSIGNED

                                                                DB2 ALIAS: OCRNC_SPAN_THRU_DT
                                                                SAS ALIAS: SPANTHRU
                                                                STANDARD ALIAS: CLM_OCRNC_SPAN_THRU_DT
                                                                TITLE ALIAS: SPAN_THRU_DT

                                                                EDIT-RULES:
                                                                YYYYMMDD

                                                                SOURCE:
                                                                CWF

 ****   CLAIM VALUE GROUP   GROUP   9   THE NUMBER OF CLAIM VALUE DATA TRAILERS PRESENT IS
                                                                DETERMINED BY THE CLAIM VALUE CODE COUNT. EFFECTIVE

```
                                             10/93, UP TO 36 OCCURRENCES CAN BE REPORTED ON AN
                                             INSTITUTIONAL CLAIM.  PRIOR TO 10/93, UP TO 10
                                             OCCURRENCES COULD BE REPORTED.

                                             OCCURS: UP TO 36 TIMES
                                                     DEPENDING ON OP_CLM_VAL_CD_CNT

                                             STANDARD ALIAS: CLM_VAL_GRP

  155. NCH VALUE TRAILER INDICATOR  CHAR      1          EFFECTIVE WITH VERSION H, THE CODE INDICATING
       CODE                                             THE PRESENCE OF A VALUE CODE TRAILER.

                                             NOTE:  DURING THE VERSION H CONVERSION THIS FIELD
                                             WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
                                             YEAR 1991).

                                             DB2 ALIAS: VAL_TRLR_IND_CD
                                             SAS ALIAS: VALIND
                                             STANDARD ALIAS: NCH_VAL_TRLR_IND_CD

                                             CODES:
                                             V = VALUE CODE TRAILER PRESENT

                                             SOURCE:
                                             NCH

  156. CLAIM VALUE CODE              CHAR     2          THE CODE INDICATING THE VALUE OF A MONETARY
                                                         CONDITION WHICH WAS USED BY THE INTERMEDIARY
                                                         TO PROCESS AN INSTITUTIONAL CLAIM.

                                             DB2 ALIAS: CLM_VAL_CD
                                             SAS ALIAS: VAL_CD
1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                                POSITIONS
              NAME                   TYPE   LENGTH BEG   END                      CONTENTS
      ------------------------------ ----   ------ ---------  ----------------------------------------------------
                                             STANDARD ALIAS: CLM_VAL_CD
                                             SYSTEM ALIAS: LTVALUE
                                             TITLE ALIAS: VALUE_CD

                                             CODES:
                                               REFER TO: CLM_VAL_TB
                                                         IN THE CODES APPENDIX
```

SOURCE:
CWF

157. CLAIM VALUE AMOUNT   PACK   6   THE AMOUNT RELATED TO THE CONDITION IDENTIFIED
                                                       IN THE CLM_VAL_CD WHICH WAS USED BY THE
                                                       INTERMEDIARY TO PROCESS THE INSTITUTIONAL
                                                       CLAIM.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: CLM_VAL_AMT
                                                       SAS ALIAS: VAL_AMT
                                                       STANDARD ALIAS: CLM_VAL_AMT
                                                       TITLE ALIAS: VALUE_AMOUNT

                                                       EDIT-RULES:
                                                       $$$$$$$$$CC

                                                       SOURCE:
                                                       CWF

 ****   CLAIM REVENUE CENTER GROUP   GROUP   224   THE NUMBER OF CLAIM REVENUE CENTER DATA TRAILERS IS
                                                       DETERMINED BY THE CLAIM REVENUE CENTER CODE COUNT.
                                                       EFFECTIVE 7/7/00, UP TO 450 OCCURRENCES MAY BE REPORT
                                                       FOR AN INSTITUTIONAL CLAIM. THE INCREASE IN THE
                                                       NUMBER OF REVENUE CENTER LINES CAUSES EACH CLAIM TO
                                                       BE BROKEN OUT INTO RECORDS/SEGMENTS (UP TO 10). EACH
                                                       RECORD CAN HAVE UP TO 45 OCCURRENCES OF REVENUE CENTE
                                                       LINES. PRIOR TO 7/7/00, UP TO 58 OCCURRENCES MAY BE
                                                       REPORTED ON AN INSTITUTIONAL CLAIM. CLAIMS SUBMITTED
                                                       PRIOR TO 10/93, CONTAINED UP TO 28 OCCURRENCES.

                                                       OCCURS: UP TO 45 TIMES
                                                               DEPENDING ON OP_REV_CNTR_CD_I_CNT

                                                       STANDARD ALIAS: CLM_REV_CNTR_GRP

                                                       COMMENT:
                                                       ****************** FOR SNF PPS *********************
                                                       THE BALANCED BUDGET ACT MODIFIED HOW PAYMENT WILL BE
                                                       MADE FOR SKILLED NURSING FACILITY (SNF) SERVICES.
                                                       EFFECTIVE WITH COST REPORTING PERIODS BEGINNING ON OR

                                                AFTER 7/1/98 (WITH ALL PROVIDERS TRANSITIONING BY
                                                6/30/99, SNFS WILL BE PAID ON A PROSPECTIVE PAYMENT
                                                SYSTEM (PPS).

                                                SNFS WILL CLASSIFY BENEFICIARIES ON THE BASIS OF
   1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                              POSITIONS
                NAME   TYPE   LENGTH BEG   END   CONTENTS
   ------------------------------ ---- ------ --------- --
                                                RESIDENTS' CHARACTERISTICS AND RESOURCE NEEDS, USING
                                                THE 44-GROUP PATIENT CLASSIFICATION SYSTEM KNOWN AS
                                                RESOURCE UTILIZATION GROUPS (RUGS), VERSION III.
                                                FACILITIES WILL USE INFORMATION FROM THE MINIMUM DATA
                                                SET (MDS), VERSION 2.0, RESIDENT ASSESSMENT INSTRUMEN
                                                (RAI) TO CLASSIFY RESIDENTS INTO THE RUG-III GROUPS.

                                                ***************** FOR OUTPATIENT PPS ***************
                                                THE BALANCED BUDGET ACT MODIFIED HOW PAYMENT WILL BE
                                                MADE FOR HOSPITAL OUTPATIENT SERVICES, CERTAIN PTB
                                                SERVICES FURNISHED TO INPATIENTS WHO HAVE NO PTA
                                                COVERAGE, CMHCS, AND LIMITED SERVICES PROVIDED BY
                                                CORFS, HOME HEALTH AGENCIES OR TO HOSPICE PATIENTS
                                                FOR THE TREATMENT OF A NON-TERMINAL ILLNESS. IMPLE-
                                                MENTATION FOR OUTPATIENT PPS (OPPS) WILL BE EFFECTIVE
                                                FOR CLAIMS WITH DATES OF SERVICE ON OR AFTER
                                                JULY 1, 2000.

                                                PAYMENT FOR SERVICES UNDER THE OPPS SYSTEM IS
                                                CALCULATED BASED ON GROUPING OUTPATIENT SERVICES
                                                INTO AMBULATORY PAYMENT CLASSIFICATIONS (APC) GROUPS.

                                                ************** FOR HOME HEALTH PPS ***************
                                                THE BALANCED BUDGET ACT OF 1997 MANDATED CHANGES IN
                                                PAYMENT AND OTHER PROVIDER REQUIREMENTS FOR HOME
                                                HEALTH. ALL HOME HEALTH AGENCIES WILL BE PAID
                                                THROUGH A PROSPECTIVE PAYMENT SYSTEM BEGINNING
                                                OCTOBER 1, 2000.

                                                UNDER HOME HEALTH PPS (HH PPS) THE UNIT OF PAYMENT
                                                WILL BE A 60-DAY EPISODE. HOME HEALTH RESOURCES
                                                GROUPS (HHRGS), ALSO CALLED HRGS REPRESENTED BY
                                                HCFA HIPPS CODING, WILL BE THE BASIS OF PAYMENT FOR
                                                EACH EPISODE; HHRGS WILL BE PRODUCED THROUGH PUBICLY

```
                                              AVAILABLE GROUPER SOFTWARE THAT WILL DETERMINE THE
                                              APPROPRIATE HHRG WHEN RESULTS OF COMPREHENSIVE
                                              ASSESSMENTS OF THE BENEFICIARY (MADE INCORPORATING
                                              THE OASIS DATA SET) ARE INPUT OR GROUPED IN THIS
                                              SOFTWARE.

  158. NCH REVENUE CENTER TRAILER   CHAR     1          EFFECTIVE WITH VERSION H, THE CODE IDENTIFYING THE
       INDICATOR CODE                                   REVENUE CENTER TRAILER.

                                              DURING THE VERSION H CONVERSION THIS FIELD WAS
                                              POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO
                                              SERVICE YEAR 1991).

                                              DB2 ALIAS: REV_CNTR_TRLR_CD
                                              SAS ALIAS: REVIND
                                              STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD

                                              CODES:
                                              R = REVENUE CODE TRAILER PRESENT

                                              SOURCE:
                                              NCH
  1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                           POSITIONS
               NAME                TYPE  LENGTH BEG   END                        CONTENTS
       ---------------------------  ----  ------ --------  ----------------------------------------------------

  159. REVENUE CENTER CODE          CHAR     4           THE PROVIDER-ASSIGNED REVENUE CODE FOR EACH COST CENT
                                                         WHICH A SEPARATE CHARGE IS BILLED (TYPE OF ACCOMMODAT
                                                         ANCILLARY).  A COST CENTER IS A DIVISION OR UNIT WITH
                                                         HOSPITAL (E.G., RADIOLOGY, EMERGENCY ROOM, PATHOLOGY)
                                                         EXCEPTION:  REVENUE CENTER CODE 0001 REPRESENTS THE T
                                                         ALL REVENUE CENTERS INCLUDED ON THE CLAIM.

                                              COBOL ALIAS: REV_CD
                                              DB2 ALIAS: REV_CNTR_CD
                                              SAS ALIAS: REV_CNTR
                                              STANDARD ALIAS: REV_CNTR_CD
                                              SYSTEM ALIAS: LTRC
                                              TITLE ALIAS: REVENUE_CENTER_CD

                                              CODES:
                                                REFER TO: REV_CNTR_TB
```

                                                IN THE CODES APPENDIX

                                                SOURCE:
                                                CWF

160. REVENUE CENTER DATE   NUM   8   EFFECTIVE WITH VERSION H, THE DATE APPLICABLE
                                                        TO THE SERVICE REPRESENTED BY THE REVENUE CENTER
                                                        CODE.   THIS FIELD MAY BE PRESENT ON ANY OF THE
                                                        INSTITUTIONAL CLAIM TYPES. FOR HOME HEALTH CLAIMS
                                                        THE SERVICE DATE SHOULD BE PRESENT ON ALL BILLS
                                                        WITH FROM DATE GREATER THAN 3/31/98. WITH THE
                                                        IMPLEMENTATION OF OUTPATIENT PPS, HOSPITALS WILL
                                                        BE REQUIRED TO ENTER LINE ITEM DATES OF SERVICE
                                                        FOR ALL OUTPATIENT SERVICES WHICH REQUIRE A HCPCS.

                                                        NOTE1: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                        10/3/97 THIS FIELD WAS POPULATED WITH DATA.
                                                        CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
                                                        ZEROES IN THIS FIELD.

                                                        NOTE2: WHEN REVENUE CENTER CODE EQUALS '0022'
                                                        (SNF PPS) AND REVENUE CENTER HCPCS CODE NOT EQUAL
                                                        TO 'AAA00' (DEFAULT FOR NO ASSESSMENT), DATE RE-
                                                        PRESENTS THE MDS RAI ASSESSMENT REFERENCE DATE.

                                                        NOTE3: WHEN REVENUE CENTER CODE EQUALS '0023'
                                                        (HHPPS), THE DATE ON THE INITIAL CLAIM (RAP) MUST
                                                        REPRESENT THE FIRST DATE OF SERVICE IN THE EPISODE.
                                                        THE FINAL CLAIM WILL MATCH THE '0023' INFORMATION
                                                        SUBMITTED ON THE INITIAL CLAIM. THE SCIC
                                                        (SIGNIFICANT CHANGE IN CONDITION) CLAIMS MAY SHOW
                                                        ADDITIONAL '0023' REVENUE LINES IN WHICH THE
                                                        DATE REPRESENTS THE DATE OF THE FIRST SERVICE
                                                        UNDER THE REVISED PLAN OF TREATMENT.

                                                        8 DIGITS UNSIGNED

                                                        DB2 ALIAS: REV_CNTR_DT
                                                        SAS ALIAS: REV_DT
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                        POSITIONS
             NAME   TYPE LENGTH BEG END   CONTENTS
     ---------------------------- ---- ------ -------- --

```
                                           STANDARD ALIAS: REV_CNTR_DT
                                           TITLE ALIAS: REV_CNTR_DATE

                                           EDIT-RULES:
                                           YYYYMMDD

                                           SOURCE:
                                           CWF
```

161. REVENUE CENTER 1ST ANSI   CHAR   5   THE FIRST CODE USED TO IDENTIFY THE
     CODE   DETAILED REASON AN ADJUSTMENT WAS MADE
                                                      (E.G. REASON FOR DENIAL OR REDUCING PAYMENT).

```
                                           NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                           7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                           CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                           SPACES IN THIS FIELD.

                                           DB2 ALIAS: REV_CNTR_ANSI1_CD
                                           SAS ALIAS: REVANSI1
                                           STANDARD ALIAS: REV_CNTR_ANSI_1_CD
                                           SYSTEM ALIAS: LTANSI
                                           TITLE ALIAS: ANSI_CD

                                           CODES:
                                             REFER TO: REV_CNTR_ANSI_TB
                                                       IN THE CODES APPENDIX

                                           SOURCE:
                                           CWF
```

162. REVENUE CENTER 2ND ANSI   CHAR   5   THE SECOND CODE USED TO IDENTIFY THE
     CODE   DETAILED REASON AN ADJUSTMENT WAS MADE
                                                      (E.G. REASON FOR DENIAL OR REDUCING PAYMENT).

```
                                           NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                           7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                           CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                           SPACES IN THIS FIELD.

                                           DB2 ALIAS: REV_CNTR_ANSI2_CD
                                           SAS ALIAS: REVANSI2
                                           STANDARD ALIAS: REV_CNTR_ANSI_2_CD
                                           TITLE ALIAS: ANSI_CD
```

```
                                                       SOURCE:
                                                       CWF

  163. REVENUE CENTER 3RD ANSI      CHAR      5         THE THIRD CODE USED TO IDENTIFY THE
       CODE                                            DETAILED REASON AN ADJUSTMENT WAS MADE
                                                       (E.G. REASON FOR DENIAL OR REDUCING PAYMENT).

                                                       NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                       SPACES IN THIS FIELD.
  1                        FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                            POSITIONS
              NAME                 TYPE  LENGTH BEG  END                       CONTENTS
       ---------------------------- ---- ------ ---------  ------------------------------------------------

                                                       DB2 ALIAS: REV_CNTR_ANSI3_CD
                                                       SAS ALIAS: REVANSI3
                                                       STANDARD ALIAS: REV_CNTR_ANSI_3_CD
                                                       TITLE ALIAS: ANSI_CD

                                                       SOURCE:
                                                       CWF

  164. REVENUE CENTER 4TH ANSI      CHAR      5         THE FOURTH CODE USED TO IDENTIFY THE
       CODE                                            DETAILED REASON AN ADJUSTMENT WAS MADE
                                                       (E.G. REASON FOR DENIAL OR REDUCING PAYMENT).

                                                       NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                       SPACES IN THIS FIELD.

                                                       DB2 ALIAS: REV_CNTR_ANSI4_CD
                                                       SAS ALIAS: REVANSI4
                                                       STANDARD ALIAS: REV_CNTR_ANSI_4_CD
                                                       TITLE ALIAS: ANSI_CD

                                                       SOURCE:
                                                       CWF

  165. REVENUE CENTER APC/HIPPS      CHAR      5         EFFECTIVE WITH OUTPATIENT PPS (OPPS), THE AMBULATORY
```

```
       CODE                                        PAYMENT CLASSIFICATION (APC) CODE USED TO IDENTIFY
                                                   GROUPINGS OF OUTPATIENT SERVICES.  APC CODES ARE
                                                   USED TO CALCULATE PAYMENT FOR SERVICES UNDER
                                                   OPPS.

                                                   EFFECTIVE WITH HOME HEALTH PPS (HHPPS), THIS FIELD
                                                   WILL ONLY BE POPULATED WITH A HIPPS CODE IF THE HIPPS
                                                   CODE THAT IS STORED IN THE HCPCS FIELD HAS BEEN
                                                   DOWNCODED AND THE NEW CODE WILL BE PLACED IN THIS
                                                   FIELD.

                                                   NOTE1: UNDER SNF PPS AND HHPPS, HIPPS CODES ARE
                                                   STORED IN THE HCPCS FIELD. **EXCEPTION: IF A
                                                   HHPPS HIPPS CODE IS DOWNCODED THE DOWNCODED
                                                   HIPPS WILL BE STORED IN THIS FIELD.

                                                   NOTE2:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                   8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                   CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                                   SPACES IN THIS FIELD.

                                                   DB2 ALIAS: REV_APC_HIPPS_CD
                                                   SAS ALIAS: APCHIPPS
                                                   STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
                                                   SYSTEM ALIAS: LTAPC
                                                   TITLE ALIAS: APC_HIPPS

                                                   CODES:
                                                     REFER TO: REV_CNTR_APC_TB
   1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                          POSITIONS
            NAME                   TYPE  LENGTH BEG   END                          CONTENTS
   ---------------------------- ---- ------ --------- --------------------------------------------------
                                                   IN THE CODES APPENDIX


                                                   SOURCE:
                                                   CWF

   166. REVENUE CENTER HCFA COMMON   CHAR    5       HCFA'S COMMON PROCEDURE CODING SYSTEM (HCPCS)
        PROCEDURE CODING SYSTEM                      IS A COLLECTION OF CODES THAT REPRESENT PROCEDURES,
        CODE                                         SUPPLIES, PRODUCTS AND SERVICES WHICH MAY BE
                                                     PROVIDED TO MEDICARE BENEFICIARIES AND TO
                                                     INDIVIDUALS ENROLLED IN PRIVATE HEALTH
```

INSURANCE PROGRAMS. THE CODES ARE DIVIDED
INTO THREE LEVELS, OR GROUPS, AS DESCRIBED
BELOW:

DB2 ALIAS: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

CODES:
   REFER TO: CLM_HIPPS_TB
               IN THE CODES APPENDIX

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
HCPCS_CD. WITH VERSION H, A PREFIX
WAS ADDED TO DENOTE THE LOCATION OF THIS FIELD
ON EACH CLAIM TYPE (INSTITUTIONAL: REV_CNTR AND
NON-INSTITUTIONAL: LINE).

NOTE: WHEN REVENUE CENTER CODE = '0022' (SNF PPS)
OR '0023' (HH PPS), THIS FIELD CONTAINS THE HEALTH
INSURANCE PPS (HIPPS) CODE. THE HIPPS CODE FOR
SNF PPS CONTAINS THE RATE CODE/ASSESSMENT TYPE THAT
IDENTIFIES (1) RUG-III GROUP THE BENEFICIARY WAS
CLASSIFIED INTO AS OF THE RAI MDS ASSESSMENT REFERENC
DATE AND (2) THE TYPE OF ASSESSMENT FOR PAYMENT PUR-
POSES.

THE HIPPS CODE FOR HOME HEALTH PPS IDENTIFIES
(1) THE THREE CASE-MIX DIMENSIONS OF THE HHRG SYSTEM,
CLINICAL, FUNCTIONAL AND UTILIZATION, FROM WHICH A
BENEFICIARY IS ASSIGNED TO ONE OF THE 80 HHRG
CATEGORIES AND (2) IT IDENTIFIES WHETHER OR NOT
THE ELEMENTS OF THE CODE WERE COMPUTED OR DERIVED.
THE HHRGS, REPRESENTED BY THE HIPPS CODING, WILL BE
THE BASIS OF PAYMENT FOR EACH EPISODE.

FOR BOTH SNF PPS & HH PPS HIPPS VALUES SEE CLM_HIPPS_

LEVEL I
   CODES AND DESCRIPTORS COPYRIGHTED BY THE AMERICAN
   MEDICAL ASSOCIATION'S CURRENT PROCEDURAL

```
                                                          TERMINOLOGY, FOURTH EDITION (CPT-4).  THESE ARE
                                                          5 POSITION NUMERIC CODES REPRESENTING PHYSICIAN
   1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                      POSITIONS
            NAME                TYPE  LENGTH BEG  END                           CONTENTS
   ----------------------------- ---- ------ --------  -----------------------------------------------------
                                                          AND NONPHYSICIAN SERVICES.

                                                          **** NOTE: ****
                                                          CPT-4 CODES INCLUDING BOTH LONG AND SHORT
                                                          DESCRIPTIONS SHALL BE USED IN ACCORDANCE WITH THE
                                                          HCFA/AMA AGREEMENT.  ANY OTHER USE VIOLATES THE
                                                          AMA COPYRIGHT.

                                                          LEVEL II
                                                            INCLUDES CODES AND DESCRIPTORS COPYRIGHTED BY
                                                            THE AMERICAN DENTAL ASSOCIATION'S CURRENT DENTAL
                                                            TERMINOLOGY, SECOND EDITION (CDT-2).  THESE ARE
                                                            5 POSITION ALPHA-NUMERIC CODES COMPRISING
                                                            THE D SERIES.  ALL OTHER LEVEL II CODES AND
                                                            DESCRIPTORS ARE APPROVED AND MAINTAINED JOINTLY
                                                            BY THE ALPHA-NUMERIC EDITORIAL PANEL (CONSISTING
                                                            OF HCFA, THE HEALTH INSURANCE ASSOCIATION OF
                                                            AMERICA, AND THE BLUE CROSS AND BLUE SHIELD
                                                            ASSOCIATION).  THESE ARE 5 POSITION ALPHA-
                                                            NUMERIC CODES REPRESENTING PRIMARILY ITEMS AND
                                                            NONPHYSICIAN SERVICES THAT ARE NOT
                                                            REPRESENTED IN THE LEVEL I CODES.

                                                          LEVEL III
                                                            CODES AND DESCRIPTORS DEVELOPED BY MEDICARE
                                                            CARRIERS FOR USE AT THE LOCAL (CARRIER) LEVEL.
                                                            THESE ARE 5 POSITION ALPHA-NUMERIC CODES IN THE
                                                            W, X, Y OR Z SERIES REPRESENTING PHYSICIAN
                                                            AND NONPHYSICIAN SERVICES THAT ARE NOT
                                                            REPRESENTED IN THE LEVEL I OR LEVEL II CODES.

   167. REVENUE CENTER HCPCS       CHAR     2            A FIRST MODIFIER TO THE PROCEDURE CODE TO ENABLE A MO
        INITIAL MODIFIER CODE                            SPECIFIC PROCEDURE IDENTIFICATION FOR THE CLAIM.

                                                          DB2 ALIAS: REV_HCPCS_MDFR_CD
                                                          SAS ALIAS: MDFR_CD1
                                                          STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD
```

```
                                              TITLE ALIAS: INITIAL_MODIFIER

                                              EDIT-RULES:
                                              CARRIER INFORMATION FILE

                                              COMMENT:
                                              PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                              HCPCS_INITL_MDFR_CD.  WITH VERSION H, A PREFIX
                                              WAS ADDED TO DENOTE THE LOCATION OF THIS FIELD
                                              ON EACH CLAIM TYPE (INSTITUTIONAL: REV_CNTR AND
                                              NON-INSTITUTIONAL: LINE).

                                              SOURCE:
                                              CWF

  168. REVENUE CENTER HCPCS SECOND  CHAR     2      A SECOND MODIFIER TO THE PROCEDURE CODE TO MAKE IT MO
       MODIFIER CODE                                SPECIFIC THAN THE FIRST MODIFIER CODE TO IDENTIFY THE
                                                    PROCEDURES PERFORMED ON THE BENEFICIARY FOR THE CLAIM
```

```
1                     FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                            POSITIONS
              NAME                  TYPE   LENGTH BEG   END                         CONTENTS
    ------------------------------  ----   ------ ---------   -------------------------------------------------
                                              DB2 ALIAS: REV_HCPCS_2ND_CD
                                              SAS ALIAS: MDFR_CD2
                                              STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
                                              TITLE ALIAS: SECOND_MODIFIER

                                              EDIT-RULES:
                                              CARRIER INFORMATION FILE

                                              COMMENT:
                                              PRIOR TO VERSION H THIS FIELD WAS NAMED:
                                              HCPCS_2ND_MDFR_CD.  WITH VERSION H, A PREFIX
                                              WAS ADDED TO DENOTE THE LOCATION OF THIS FIELD
                                              ON EACH CLAIM TYPE (INSTITUTIONAL: REV_CNTR AND
                                              NON-INSTITUTIONAL: LINE).

                                              SOURCE:
                                              CWF

  169. REVENUE CENTER HCPCS THIRD   CHAR     2      EFFECTIVE WITH VERSION I, A THIRD MODIFIER TO THE
       MODIFIER CODE                                PROCEDURE CODE TO MAKE  IT MORE SPECIFIC THAN THE
```

```
                                            SECOND MODIFIER CODE TO IDENTIFY THE PROCEDURES
                                            PERFORMED ON THE BENEFICIARY FOR THE CLAIM.


                                            DB2 ALIAS: REV_HCPCS_3RD_CD
                                            SAS ALIAS: MDFR_CD3
                                            STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
                                            TITLE ALIAS: THIRD_MODIFIER


                                            EDIT-RULES:
                                            CARRIER INFORMATION FILE


                                            COMMENT:
                                            NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                            8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                            CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                            SPACES IN THIS FIELD.


                                            SOURCE:
                                            CWF

  170. REVENUE CENTER HCPCS FOURTH  CHAR     2          EFFECTIVE WITH VERSION I, A FOURTH MODIFIER TO THE
       MODIFIER CODE                                    PROCEDURE CODE TO MAKE IT MORE SPECIFIC THAN THE
                                                        THIRD MODIFIER CODE TO IDENTIFY THE PROCEDURES
                                                        PERFORMED ON THE BENEFICIARY FOR THE CLAIM.


                                            DB2 ALIAS: REV_HCPCS_4TH_CD
                                            SAS ALIAS: MDFR_CD4
                                            STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
                                            TITLE ALIAS: FOURTH_MODIFIER


                                            EDIT-RULES:
                                            CARRIER INFORMATION FILE


                                            COMMENT:
                                            NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                            8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
  1                    FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                        POSITIONS
             NAME                TYPE  LENGTH BEG   END                            CONTENTS
    ----------------------------  ----  ------ --------  -------------------------------------------------------
                                            CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                            SPACES IN THIS FIELD.
```

SOURCE:
CWF

171. REVENUE CENTER HCPCS FIFTH   CHAR   2
      MODIFIER CODE

EFFECTIVE WITH VERSION I, A FIFTH MODIFIER TO THE
PROCEDURE CODE TO MAKE IT MORE SPECIFIC THAN THE
FOURTH MODIFIER CODE TO IDENTIFY THE PROCEDURES
PERFORMED ON THE BENEFICIARY FOR THE CLAIM.

DB2 ALIAS: REV_HCPCS_5TH_CD
SAS ALIAS: MDFR_CD5
STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
TITLE ALIAS: FIFTH_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
SPACES IN THIS FIELD.

SOURCE:
CWF

172. REVENUE CENTER PAYMENT   CHAR   2
      METHOD INDICATOR CODE

EFFECTIVE WITH VERSION 'I', THE CODE USED TO
IDENTIFY HOW THE SERVICE IS PRICED FOR PAYMENT.
THIS FIELD IS MADE UP OF TWO PIECES OF DATA,
1ST POSITION BEING THE SERVICE INDICATOR AND
THE 2ND POSITION BEING THE PAYMENT INDICATOR.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: REV_PMT_MTHD_CD
SAS ALIAS: PMTMTHD
STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
SYSTEM ALIAS: LTPMTHD
TITLE ALIAS: PMT_MTHD

CODES:
  REFER TO: REV_CNTR_PMT_MTHD_IND_TB

                              IN THE CODES APPENDIX

                                          SOURCE:
                                          CWF

  173. REVENUE CENTER DISCOUNT   CHAR   1   EFFECTIVE WITH VERSION 'I', FOR ALL SERVICES
       INDICATOR CODE   SUBJECT TO OUTPATIENT PPS, THIS CODE REPRESENTS
                                                           A FACTOR THAT SPECIFIES THE AMOUNT OF ANY APC
                                                           DISCOUNT. THE DISCOUNTING FACTOR IS APPLIED
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ -------- ---
                                                           TO A LINE ITEM WITH A SERVICE INDICATOR (PART
                                                           OF THE REV_CNTR_PMT_MTHD_IND_CD) OF 'T'. THE
                                                           FLAG IS APPLICABLE WHEN MORE THAN ONE SIGNIFICANT
                                                           PROCEDURE IS PERFORMED. **IF THERE IS NO DIS-
                                                           COUNTING THE FACTOR WILL BE 1.0.**

                                                           NOTE1: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                           8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                           CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                                           SPACES IN THIS FIELD.

                                                           DB2 ALIAS: REV_DSCNT_IND_CD
                                                           SAS ALIAS: DSCNTIND
                                                           STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
                                                           SYSTEM ALIAS: LTDSCNT
                                                           TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

                                                           CODES:
                                                           DISCOUNTING FORMULAS
                                                           1 = 1.0
                                                           2 = (1.0+D(U-1))/U
                                                           3 = T/U
                                                           4 = (1+D)/U
                                                           5 = D
                                                           6 = TD/U
                                                           7 = D(1+D)/U
                                                           8 = 2.0/U

                                                           SOURCE:
                                                           CWF

```
174. REVENUE CENTER PACKAGING     CHAR     1                 EFFECTIVE WITH VERSION 'I', FOR ALL SERVICES
     INDICATOR CODE                                          SUBJECT TO OUTPATIENT PPS, THE CODE USED TO
                                                             IDENTIFY THOSE SERVICES THAT ARE PACKAGED/
                                                             BUNDLED WITH ANOTHER SERVICE.

                                                             NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                             8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                             CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                                             SPACES IN THIS FIELD.

                                                             DB2 ALIAS: REV_PACKG_IND_CD
                                                             SAS ALIAS: PACKGIND
                                                             STANDARD ALIAS: REV_CNTR_PACKG_IND_CD
                                                             SYSTEM ALIAS: LTPACKG
                                                             TITLE ALIAS: REV_CNTR_PACKG_IND

                                                             CODES:
                                                             0 = NOT PACKAGED
                                                             1 = PACKAGED SERVICE (SERVICE INDICATOR N)
                                                             2 = PACKAGED AS PART OF PARTIAL HOSPITALIZATION
                                                                 PER DIEM OR DAILY MENTAL HEALTH SERVICE
                                                                 PER DIEM

                                                             SOURCE:
                                                             CWF
1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                             POSITIONS
           NAME                TYPE  LENGTH BEG  END                        CONTENTS
     ------------------------  ----  ------ ---------  ------------------------------------------------------

175. REVENUE CENTER PRICING      CHAR     2                 EFFECTIVE WITH VERSION 'I', THE CODE USED
     INDICATOR CODE                                          TO IDENTIFY IF THERE WAS A DEVIATION FROM
                                                             THE STANDARD METHOD OF CALCULATING PAYMENT
                                                             AMOUNT.

                                                             NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                             8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                             CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                                             SPACES IN THIS FIELD.

                                                             DB2 ALIAS: REV_PRICNG_IND_CD
                                                             SAS ALIAS: PRICNG
```

```
                                        STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD
                                        SYSTEM ALIAS: LTPRICNG
                                        TITLE ALIAS: REV_CNTR_PRICNG_IND

                                        CODES:
                                          REFER TO: REV_CNTR_PRICNG_IND_TB
                                                    IN THE CODES APPENDIX

                                        SOURCE:
                                        CWF

176. REVENUE CENTER OBLIGATION    CHAR    1       EFFECTIVE WITH VERSION 'I' THE CODE USED
     TO ACCEPT AS FULL (OTAF)                     TO INDICATE THAT THE PROVIDER WAS OBLIGATED
     PAYMENT CODE                                 TO ACCEPT AS FULL PAYMENT THE AMOUNT RE-
                                                  CEIVED FROM THE PRIMARY (OR SECONDARY) PAYER.

                                        NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                        7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                        CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                        SPACES IN THIS FIELD.

                                        DB2 ALIAS: REV_OTAF1_IND_CD
                                        SAS ALIAS: OTAF_1
                                        STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD
                                        TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD

                                        EDIT-RULES:
                                        Y = PROVIDER IS OBLIGATED TO ACCEPT THE PAYMENT
                                            AS PAYMENT IN FULL FOR THE SERVICE.
                                        N OR BLANK  = PROVIDER IS NOT OBLIGATED TO ACCEPT
                                            THE PAYMENT, OR THERE IS NO PAYMENT BY A PRIOR
                                            PAYER.

                                        SOURCE:
                                        CWF

177. REVENUE CENTER OBLIGATION    CHAR    1       ***********FIELD NOT POPULATED*************
     TO ACCEPT AS FULL (OTAF)                     THIS FIELD WAS INTENDED TO COLLECT INFORMATION
     PAYMENT CODE                                 FOR TWO PAYERS IF MEDICARE WAS TERTIARY.  IT
                                                  WAS DISCOVERED THAT MSP SYSTEM ONLY DEALS WITH
                                                  ONE PAYER SO THERE IS NO NEED TO HAVE 2 OTAF
                                                  FIELDS.
```

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

```
                                              POSITIONS
           NAME                TYPE   LENGTH BEG   END                    CONTENTS
     ------------------------   ----   ------ ---------    ------------------------------------------------
                                                           DB2 ALIAS: REV_OTAF2_IND_CD
                                                           SAS ALIAS: OTAF_2
                                                           STANDARD ALIAS: REV_CNTR_OTAF_2_IND_CD
                                                           TITLE ALIAS: REV_CNTR_OTAF_2_IND_CD

                                                           SOURCE:
                                                           CWF

     178. REVENUE CENTER IDE, NDC,   CHAR     24           EFFECTIVE WITH VERSION H, THE EXEMPTION NUMBER
          UPC NUMBER                                       ASSIGNED BY THE FOOD AND DRUG ADMINISTRATION (FDA)
                                                           TO AN INVESTIGATIONAL DEVICE AFTER A MANUFACTURER
                                                           HAS BEEN APPROVED BY FDA TO CONDUCT A CLINICAL
                                                           TRIAL ON THAT DEVICE.   HCFA ESTABLISHED A NEW
                                                           POLICY OF COVERING CERTAIN IDE'S WHICH WAS
                                                           IMPLEMENTED IN CLAIMS PROCESSING ON 10/1/96
                                                           (WHICH IS NCH WEEKLY PROCESS 10/4/96) FOR SERVICE
                                                           DATES BEGINNING 10/1/95.  IDE'S ARE ALWAYS
                                                           ASSOCIATED WITH REVENUE CENTER CODE '0624'.

                                                           NOTE1:  PRIOR TO VERSION H A 'DUMMY' REVENUE
                                                           CENTER CODE '0624' TRAILER WAS CREATED TO STORE
                                                           IDE'S.   THE IDE NUMBER WAS HOUSED IN TWO FIELDS:
                                                           HCPCS CODE AND HCPCS INITIAL MODIFIER; THE SECOND
                                                           MODIFIER CONTAINED THE VALUE 'ID'.   THERE CAN BE
                                                           UP TO 7 DISTINCT IDE NUMBERS ASSOCIATED WITH AN
                                                           '0624' DUMMY TRAILER.  DURING THE VERSION H CON-
                                                           VERSION IDE'S WERE MOVED FROM THE DUMMY '0624'
                                                           TRAILER TO THIS DEDICATED FIELD.

                                                           NOTE2:  EFFECTIVE WITH VERSION 'I', THIS FIELD WAS
                                                           RENAMED TO EVENTUALLY ACCOMMODATE THE NATIONAL DRUG C
                                                           (NDC) AND THE UNIVERSAL PRODUCT CODE (UPC).  THIS FIE
                                                           COULD CONTAIN EITHER OF THESE 3 FIELDS (THERE WOULD N
                                                           BE AN INSTANCE WHERE MORE THAN ONE WOULD COME IN ON
                                                           A CLAIM).  THE SIZE OF THIS FIELD WAS EXPANDED TO X(2
                                                           TO ACCOMMODATE EITHER OF THE NEW FIELDS (UNDER VERSIO
                                                           'H' IT WAS X(7).  DATA ANAMOLY/LIMITATION:  DURING AN
                                                           CWFMQA REVIEW AN EDIT REVEALED THE IDE WAS MISSING.
                                                           THE PROBLEM OCCURS IN CLAIM WITH AN NCH WEEKLY PRO-
                                                           CESS DATES OF 6/9/00 THROUGH 9/8/00.  DURING PROCESSI
```

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                                          OF THE NEW FORMAT THE PROGRAM RECEIVES THE IDE BUT
                                          THEN BLANKED OUT THE DATA.


                                          DB2 ALIAS: IDE_NDC_UPC_NUM
                                          SAS ALIAS: IDENDC
                                          STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
                                          TITLE ALIAS: IDE_NDC_UPC


                                          SOURCE:
                                          CWF

   179. REVENUE CENTER UNIT COUNT    PACK      4        A QUANTITATIVE MEASURE (UNIT) OF THE NUMBER OF TIMES
                                                        SERVICE OR PROCEDURE BEING REPORTED WAS PERFORMED ACC
                                                        TO THE REVENUE CENTER/HCPCS CODE DEFINITION AS DESCRI
                                                        AN INSTITUTIONAL CLAIM.


 1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                       POSITIONS
             NAME                 TYPE  LENGTH BEG  END                          CONTENTS
   -----------------------------  ----  ------ --------  ----------------------------------------------------
                                                        DEPENDING ON TYPE OF SERVICE, UNITS ARE MEASURED BY N
                                                        OF COVERED DAYS IN A PARTICULAR ACCOMMODATION, PINTS
                                                        BLOOD, EMERGENCY ROOM VISITS, CLINIC VISITS, DIALYSIS
                                                        TREATMENTS (SESSIONS OR DAYS), OUTPATIENT THERAPY VIS
                                                        AND OUTPATIENT CLINICAL DIAGNOSTIC LABORATORY TESTS.


                                                        NOTE1:  WHEN REVENUE CENTER CODE = '0022' (SNF PPS) T
                                                        COUNT WILL REFLECT THE NUMBER OF COVERED DAYS FOR EAC
                                                        CODE AND, IF APPLICABLE, THE NUMBER OF VISITS FOR EAC
                                                        THERAPY CODE.


                                                        7 DIGITS SIGNED


                                                        DB2 ALIAS: REV_CNTR_UNIT_CNT
                                                        SAS ALIAS: REV_UNIT
                                                        STANDARD ALIAS: REV_CNTR_UNIT_CNT
                                                        TITLE ALIAS: UNITS


                                                        SOURCE:
                                                        CWF

   180. REVENUE CENTER RATE AMOUNT   PACK      6        CHARGES RELATING TO UNIT COST ASSOCIATED WITH
                                                        THE REVENUE CENTER CODE.  EXCEPTION (ENCOUNTER
```

DATA ONLY): IF PLAN (E.G. MCO) DOES NOT KNOW
THE ACTUAL RATE FOR THE ACCOMMODATIONS, $1 WILL
BE REPORTED IN THE FIELD.

NOTE1: FOR SNF PPS CLAIMS (WHEN REVENUE CENTER
CODE EQUALS '0022'), HCFA HAS DEVELOPED A SNF
PRICER TO COMPUTE THE RATE BASED ON THE PROVIDER
SUPPLIED CODING FOR THE MDS RUGS III GROUP AND
ASSESSMENT TYPE (HIPPS CODE, STORED IN REVENUE
CENTER HCPCS CODE FIELD).

NOTE2: FOR OP PPS CLAIMS, HCFA HAS DEVELOPED A
PRICER TO COMPUTE THE RATE BASED ON THE AMBULATORY
PAYMENT CLASSIFICATION (APC), DISCOUNT FACTOR,
UNITS OF SERVICE AND THE WAGE INDEX.

NOTE3: UNDER HH PPS (WHEN REVENUE CENTER
CODE EQUALS '0023'), HCFA HAS DEVELOPED A HHA
PRICER TO COMPUTE THE RATE. ON THE RAP, THE RATE IS
DETERMINED USING THE CASE MIX WEIGHT ASSOCIATED WITH
THE HIPPS CODE, ADJUSTING IT FOR THE WAGE INDEX
FOR THE BENEFICIARY'S SITE OF SERVICE, THEN
MULTIPLYING THE RESULT BY 60% OR 50%, DEPENDING ON
WHETHER OR NOT THE RAP IS FOR A FIRST EPISODE.

ON THE FINAL CLAIM, THE HIPPS CODE COULD CHANGE THE
PAYMENT IF THE THERAPY THRESHOLD IS NOT MET, OR
PARTIAL EPISODE PAYMENT (PEP) ADJUSTMENT OR A
SIGNIFICANT CHANGE IN CONDITION (SCIC) ADJUSTMENT.
IN CASES OF SCICS, THERE WILL BE MORE THAN ONE
'0023' REVENUE CENTER LINE, EACH REPRESENTING THE
PAYMENT MADE AT EACH CASE-MIX LEVEL.

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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                                         POSITIONS
        NAME                     TYPE  LENGTH BEG   END                              CONTENTS
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                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: REV_CNTR_RATE_AMT
                                                          SAS ALIAS: REV_RATE
                                                          STANDARD ALIAS: REV_CNTR_RATE_AMT
                                                          TITLE ALIAS: CHARGE_PER_UNIT
```

EFFECTIVE-DATE: 10/01/1993

COMMENT:
PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
S9(7)V99.

SOURCE:
CWF

181. REVENUE CENTER BLOOD   PACK   6   EFFECTIVE WITH VERSION 'I', THE AMOUNT OF MONEY
     DEDUCTIBLE AMOUNT   FOR WHICH THE INTERMEDIARY DETERMINED THE
                                                      BENEFICIARY IS LIABLE FOR THE BLOOD DEDUCTIBLE
                                                      FOR THE LINE ITEM SERVICE.

                                                      NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                      7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                      CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                      SPACES IN THIS FIELD.

                                                      9.2 DIGITS SIGNED

                                                      DB2 ALIAS: REV_BLOOD_DDCTBL
                                                      SAS ALIAS: REVBLOOD
                                                      STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT
                                                      TITLE ALIAS: BLOOD_DDCTBL_AMT

                                                      SOURCE:
                                                      CWF

182. REVENUE CENTER CASH   PACK   6   EFFECTIVE WITH VERSION 'I' THE AMOUNT OF CASH
     DEDUCTIBLE AMOUNT   DEDUCTIBLE THE BENEFICIARY PAID FOR THE LINE
                                                      ITEM SERVICE.

                                                      NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                      7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                      CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                      SPACES IN THIS FIELD.

                                                      9.2 DIGITS SIGNED

                                                      DB2 ALIAS: REV_CASH_DDCTBL
                                                      SAS ALIAS: REVDCTBL
                                                      STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT

```
                                          TITLE ALIAS: CASH_DDCTBL

                                          SOURCE:
                                          CWF

  183. REVENUE CENTER                  PACK    6         EFFECTIVE WITH VERSION 'I', THE AMOUNT OF
1                          FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                       POSITIONS
             NAME                TYPE  LENGTH BEG  END                          CONTENTS
      ------------------------------ ----  ------ ---------  ---------------------------------------------------
      COINSURANCE/WAGE ADJUSTED                              COINSURANCE APPLICABLE TO THE LINE ITEM
      COINSURANCE AMOUNT                                     SERVICE DEFINED BY THE REVENUE CENTER AND
                                                             HCPCS CODES.  FOR THOSE SERVICES SUBJECT TO
                                                             OUTPATIENT PPS, THE APPLICABLE COINSURANCE
                                                             IS WAGE ADJUSTED.

                                                             NOTE1:  THIS FIELD WILL HAVE EITHER A ZERO
                                                             (FOR SERVICES FOR WHICH COINSURANCE IS NOT
                                                             APPLICABLE), A REGULAR COINSURANCE AMOUNT
                                                             (CALCULATED ON EITHER CHARGES OR A FEE
                                                             SCHEDULE) OR IF SUBJECT TO OP PPS THE NATIONAL
                                                             COINSURANCE AMOUNT WILL BE WAGE ADJUSTED.
                                                             THE WAGE ADJUSTED COINSURANCE IS BASED ON THE
                                                             MSA WHERE THE PROVIDER IS LOCATED OR ASSIGNED
                                                             AS A RESULT OF A RECLASSIFICATION.

                                                             NOTE2:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                             8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                             CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
                                                             SPACES IN THIS FIELD.

                                                             9.2 DIGITS SIGNED

                                                             DB2 ALIAS: ADJSTD_COINSRNC
                                                             SAS ALIAS: WAGEADJ
                                                             STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT
                                                             TITLE ALIAS: WAGE_ADJSTD_COINS

                                                             SOURCE:
                                                             CWF

  184. REVENUE CENTER REDUCED         PACK    6         EFFECTIVE WITH VERSION 'I', FOR ALL SERVICES
       COINSURANCE AMOUNT                                    SUBJECT TO OUTPATIENT PPS, THE AMOUNT OF
```

COINSURANCE APPLICABLE TO THE LINE FOR A
PARTICULAR SERVICE (HCPCS) FOR WHICH THE
PROVIDER HAS ELECTED TO REDUCE THE COINSURANCE
AMOUNT.

NOTE1: THE REDUCED COINSURANCE AMOUNT CANNOT
BE LOWER THAN 20% OF THE PAYMENT RATE FOR THE
APC LINE.

NOTE2: BEGINNING WITH NCH WEEKLY PROCESS DATE
8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
SPACES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: RDCD_COINSRNC
SAS ALIAS: RDCDCOIN
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS

SOURCE:
CWF

1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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                                                POSITIONS
            NAME                TYPE  LENGTH BEG   END                          CONTENTS
   ----------------------------  ----  ------ ---------   --------------------------------------------------

   185. REVENUE CENTER 1ST MEDICARE  PACK    6                 EFFECTIVE WITH VERSION 'I', THE AMOUNT PAID BY
        SECONDARY PAYER PAID                                   THE PRIMARY PAYER WHEN THE PAYER IS PRIMARY TO
        AMOUNT                                                 MEDICARE (MEDICARE IS SECONDARY OR TERTIARY).

                                                              NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                              7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                              CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                              SPACES IN THIS FIELD.

                                                              9.2 DIGITS SIGNED

                                                              DB2 ALIAS: REV_MSP1_PD_AMT
                                                              SAS ALIAS: REV_MSP1
                                                              STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
                                                              TITLE ALIAS: MSP PAID AMOUNT
```

                                                       SOURCE:
                                                       CWF

186. REVENUE CENTER 2ND MEDICARE PACK   6   EFFECTIVE WITH VERSION 'I', THE AMOUNT PAID BY
     SECONDARY PAYER PAID   THE SECONDARY PAYER WHEN TWO PAYERS ARE PRIMARY
     AMOUNT   TO MEDICARE (MEDICARE IS THE TERTIARY PAYER).

                                                       NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                       SPACES IN THIS FIELD.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: REV_MSP2_PD_AMT
                                                       SAS ALIAS: REV_MSP2
                                                       STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
                                                       TITLE ALIAS: MSP PAID AMOUNT

                                                       SOURCE:
                                                       CWF

187. REVENUE CENTER PROFESSIONAL PACK   6   ************FIELD NOT POPULATED*************
     COMPONENT AMOUNT   INTENDED TO BE POPULATED FOR LINE ITEM SERVICES
                                                       SUBJECT TO PPS, AS THE AMOUNT ASSOCIATED WITH
                                                       VALUE CODE '05'. HOWEVER, WITH LINE ITEM DATE
                                                       OF SERVICE REPORTING, THERE IS NO WAY TO
                                                       CORRECTLY ALLOCATE PROFESSIONAL COMPONENT CHARGES
                                                       REPORTED IN VALUE CODE '05' TO SPECIFIC LINE ITEMS
                                                       ON THE CLAIM.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: REV_PROFNL_CMPNT
                                                       SAS ALIAS: REVPCCHG
                                                       STANDARD ALIAS: REV_CNTR_PROFNL_CMPNT_AMT
                                                       TITLE ALIAS: PROFNL_CMPNT_CHARGES

                                                       SOURCE:
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                        POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS

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      -------------------------- ---- ------ -------- ----------------------------------------------------
                                                        CWF

188.  REVENUE CENTER PROVIDER      PACK     6          EFFECTIVE WITH VERSION 'I', THE AMOUNT PAID
      PAYMENT AMOUNT                                   TO THE PROVIDER FOR THE SERVICES REPORTED
                                                       ON THE LINE ITEM.

                                                       NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                       SPACES IN THIS FIELD.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: REV_PRVDR_PMT_AMT
                                                       SAS ALIAS: RPRVDPMT
                                                       STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
                                                       TITLE ALIAS: REV_PRVDR_PMT

                                                       SOURCE:
                                                       CWF

189.  REVENUE CENTER BENEFICIARY   PACK     6          EFFECTIVE WITH VERSION I, THE AMOUNT PAID
      PAYMENT AMOUNT                                   TO THE BENEFICIARY FOR THE SERVICES REPORTED
                                                       ON THE LINE ITEM.

                                                       NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                                       7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
                                                       CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                                       SPACES IN THIS FIELD.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: REV_BENE_PMT_AMT
                                                       SAS ALIAS: RBENEPMT
                                                       STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
                                                       TITLE ALIAS: REV_BENE_PMT

                                                       SOURCE:
                                                       CWF

190.  REVENUE CENTER PATIENT       PACK     6          EFFECTIVE WITH VERSION I, THE AMOUNT PAID
      RESPONSIBILITY PAYMENT                           BY THE BENEFICIARY TO THE PROVIDER FOR THE
      AMOUNT                                           LINE ITEM SERVICE.
```

```
                                          NOTE:  BEGINNING WITH NCH WEEKLY PROCESS DATE
                                          7/7/00 THIS FIELD WAS POPULATED WITH DATA.
                                          CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
                                          ZEROES IN THIS FIELD.

                                          9.2 DIGITS SIGNED

                                          DB2 ALIAS: REV_PTNT_RESP_AMT
                                          SAS ALIAS: PTNTRESP
                                          STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
                                          TITLE ALIAS: REV_PTNT_RESP
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1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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                                              POSITIONS
            NAME                 TYPE  LENGTH BEG  END                         CONTENTS
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                                                          SOURCE:
                                                          CWF

    191. REVENUE CENTER PAYMENT   PACK      6              EFFECTIVE WITH VERSION 'I', THE LINE ITEM
         AMOUNT                                            MEDICARE PAYMENT AMOUNT FOR THE SPECIFIC
                                                           REVENUE CENTER.

                                                           UNDER OP PPS, PRICER WILL COMPUTE THE
                                                           STANDARD OPPS PAYMENT FOR A LINE ITEM BASED
                                                           ON THE PAYMENT APC.

                                                           UNDER HH PPS, PRICER WILL COMPUTE/RETURN
                                                           A LINE ITEM PAYMENT AMOUNT FOR THE CASE-MIXED,
                                                           WAGE-INDEX ADJUSTED HIPPS CODE ASSIGNED TO
                                                           THE '0023' REVENUE CENTER LINE.  THE HIPPS
                                                           CODE WILL BE STORED IN THE REVENUE CENTER
                                                           HCPCS CODE FIELD.

                                                           9.2 DIGITS SIGNED

                                                           COMMON ALIAS: REIMBURSEMENT
                                                           DB2 ALIAS: REV_CNTR_PMT_AMT
                                                           SAS ALIAS: REVPMT
                                                           STANDARD ALIAS: REV_CNTR_PMT_AMT
                                                           TITLE ALIAS: REIMBURSEMENT
```

                                                     EDIT-RULES:
                                                     $$$$$$$$$CC

                                                     SOURCE:
                                                     CWF

192. REVENUE CENTER TOTAL CHARGE   PACK   6   THE TOTAL CHARGES (COVERED AND NON-COVERED) FOR ALL
     AMOUNT   ACCOMMODATIONS AND SERVICES (RELATED TO THE REVENUE C
                                                     FOR A BILLING PERIOD BEFORE REDUCTION FOR THE DEDUCTI
                                                     COINSURANCE AMOUNTS AND BEFORE AN ADJUSTMENT FOR THE
                                                     SERVICES PROVIDED. NOTE: FOR ACCOMMODATION REVENUE C
                                                     TOTAL CHARGES MUST EQUAL THE RATE TIMES UNITS (DAYS).

                                                     EXCEPTIONS:
                                                     (1) FOR SNF RUGS DEMO CLAIMS ONLY (9000 SERIES REVEN
                                                     CENTER CODES), THIS FIELD CONTAINS SNF CUSTOMARY
                                                     ACCOMMODATION CHARGE, (IE., CHARGES RELATED TO THE
                                                     ACCOMMODATION REVENUE CENTER CODE THAT WOULD HAVE BEE
                                                     APPLICABLE IF THE PROVIDER HAD NOT BEEN PARTICIPATING
                                                     DEMO).

                                                     (2) FOR SNF PPS (NON DEMO CLAIMS), WHEN REVENUE CENT
                                                     = '0022', THE TOTAL CHARGES WILL BE ZERO.

                                                     (3) FOR HOME HEALTH PPS (RAPS), WHEN REVENUE CENTER
                                                     '0023', THE TOTAL CHARGES WILL EQUAL THE DOLLAR AMOUN
                                                     THE '0023' LINE.

                                                     (4) FOR HOME HEALTH PPS (FINAL CLAIM), WHEN REVENUE C
                                                     CODE = '0023', THE TOTAL CHARGES WILL BE THE SUM OF T
1   FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

                                          POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     ------------------------------ ---- ------ --------- ---
                                                     REVENUE CENTER CODE LINES (OTHER THAN '0023').

                                                     (5) FOR ENCOUNTER DATA, IF THE PLAN (E.G. MCO) DOES
                                                     KNOW THE ACTUAL CHARGES FOR THE ACCOMMODATIONS THE TO
                                                     CHARGES WILL BE $1 (RATE) TIMES UNITS (DAYS).

                                                     9.2 DIGITS SIGNED

                                                     DB2 ALIAS: REV_TOT_CHRG_AMT

```
                                                  SAS ALIAS: REV_CHRG
                                                  STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
                                                  TITLE ALIAS: REVENUE_CENTER_CHARGES


                                                  EDIT-RULES:
                                                  $$$$$$$$$CC


                                                  COMMENT:
                                                  PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
                                                  S9(7)V99.


                                                  SOURCE:
                                                  CWF

193.  REVENUE CENTER NON-COVERED  PACK    6        THE CHARGE AMOUNT RELATED TO A REVENUE CENTER CODE FO
      CHARGE AMOUNT                                SERVICES THAT ARE NOT COVERED BY MEDICARE.

                                                  NOTE:  PRIOR TO VERSION H THE FIELD SIZE WAS S9(7)V99
                                                  THE ELEMENT WAS ONLY PRESENT ON THE INPATIENT/SNF FOR
                                                  AS OF NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS
                                                  TO ALL INSTITUTIONAL CLAIM TYPES.


                                                  9.2 DIGITS SIGNED


                                                  DB2 ALIAS: REV_NCVR_CHRG_AMT
                                                  SAS ALIAS: REV_NCVR
                                                  STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
                                                  TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES


                                                  EDIT-RULES:
                                                  $$$$$$$$$CC


                                                  SOURCE:
                                                  CWF

194.  REVENUE CENTER DEDUCTIBLE    CHAR    1        CODE INDICATING WHETHER THE REVENUE CENTER CHARGES
      COINSURANCE CODE                             ARE SUBJECT TO DEDUCTIBLE AND/OR COINSURANCE.


                                                  DB2 ALIAS: DDCTBL_COINSRNC_CD
                                                  SAS ALIAS: REVDEDCD
                                                  STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD
                                                  TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD


                                                  CODES:
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                                   REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
                                             IN THE CODES APPENDIX

1                      FI OUTPATIENT CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001


                                        POSITIONS
                NAME                 TYPE  LENGTH BEG  END                          CONTENTS
     --------------------------- ---- ------ -------- --------------------------------------------------
                                                          SOURCE:
                                                          CWF

   195. FILLER                     CHAR    50

   196. END OF RECORD CODE         CHAR     3           EFFECTIVE WITH VERSION 'I', THE CODE USED
                                                         TO IDENTIFY THE END OF A RECORD/SEGMENT OR
                                                         THE END OF THE CLAIM.

                                                         DB2 ALIAS: END_REC_CD
                                                         SAS ALIAS: EOR
                                                         STANDARD ALIAS: END_REC_CD
                                                         TITLE ALIAS: END_OF_REC

                                                         CODES:
                                                         EOR = END OF RECORD/SEGMENT
                                                         EOC= END OF CLAIM

                                                         COMMENT:
                                                         PRIOR TO VERSION I THIS FIELD WAS NAMED:
                                                         END_REC_CNSTNT.

                                                         SOURCE:
                                                         NCH

1       BENE_IDENT_TB                        BENEFICIARY IDENTIFICATION CODE (BIC) TABLE
        -------------                        ------------------------------------------


                             SOCIAL SECURITY ADMINISTRATION:

                             A  = PRIMARY CLAIMANT
                             B  = AGED WIFE, AGE 62 OR OVER (1ST
                                  CLAIMANT)
                             B1 = AGED HUSBAND, AGE 62 OR OVER (1ST
                                  CLAIMANT)
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B2 = YOUNG WIFE, WITH A CHILD IN HER CARE
     (1ST CLAIMANT)
B3 = AGED WIFE (2ND CLAIMANT)
B4 = AGED HUSBAND (2ND CLAIMANT)
B5 = YOUNG WIFE (2ND CLAIMANT)
B6 = DIVORCED WIFE, AGE 62 OR OVER (1ST
     CLAIMANT)
B7 = YOUNG WIFE (3RD CLAIMANT)
B8 = AGED WIFE (3RD CLAIMANT)
B9 = DIVORCED WIFE (2ND CLAIMANT)
BA = AGED WIFE (4TH CLAIMANT)
BD = AGED WIFE (5TH CLAIMANT)
BG = AGED HUSBAND (3RD CLAIMANT)
BH = AGED HUSBAND (4TH CLAIMANT)
BJ = AGED HUSBAND (5TH CLAIMANT)
BK = YOUNG WIFE (4TH CLAIMANT)
BL = YOUNG WIFE (5TH CLAIMANT)
BN = DIVORCED WIFE (3RD CLAIMANT)
BP = DIVORCED WIFE (4TH CLAIMANT)
BQ = DIVORCED WIFE (5TH CLAIMANT)
BR = DIVORCED HUSBAND (1ST CLAIMANT)
BT = DIVORCED HUSBAND (2ND CLAIMANT)
BW = YOUNG HUSBAND (2ND CLAIMANT)
BY = YOUNG HUSBAND (1ST CLAIMANT)
C1-C9,CA-CZ = CHILD (INCLUDES MINOR, STUDENT
               OR DISABLED CHILD)
D  = AGED WIDOW, 60 OR OVER (1ST CLAIMANT)
D1 = AGED WIDOWER, AGE 60 OR OVER (1ST
     CLAIMANT)
D2 = AGED WIDOW (2ND CLAIMANT)
D3 = AGED WIDOWER (2ND CLAIMANT)
D4 = WIDOW (REMARRIED AFTER ATTAINMENT OF
     AGE 60) (1ST CLAIMANT)
D5 = WIDOWER (REMARRIED AFTER ATTAINMENT OF
     AGE 60) (1ST CLAIMANT)
D6 = SURVIVING DIVORCED WIFE, AGE 60 OR OVER
     (1ST CLAIMANT)
D7 = SURVIVING DIVORCED WIFE (2ND CLAIMANT)
D8 = AGED WIDOW (3RD CLAIMANT)
D9 = REMARRIED WIDOW (2ND CLAIMANT)
DA = REMARRIED WIDOW (3RD CLAIMANT)
DD = AGED WIDOW (4TH CLAIMANT)
DG = AGED WIDOW (5TH CLAIMANT)
DH = AGED WIDOWER (3RD CLAIMANT)
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                              DJ = AGED WIDOWER (4TH CLAIMANT)
                              DK = AGED WIDOWER (5TH CLAIMANT)
                              DL = REMARRIED WIDOW (4TH CLAIMANT)
                              DM = SURVIVING DIVORCED HUSBAND (2ND
                                   CLAIMANT)
                              DN = REMARRIED WIDOW (5TH CLAIMANT)
  1       BENE_IDENT_TB               BENEFICIARY IDENTIFICATION CODE (BIC) TABLE
          -------------               ------------------------------------------

                              DP = REMARRIED WIDOWER (2ND CLAIMANT)
                              DQ = REMARRIED WIDOWER (3RD CLAIMANT)
                              DR = REMARRIED WIDOWER (4TH CLAIMANT)
                              DS = SURVIVING DIVORCED HUSBAND (3RD
                                   CLAIMANT)
                              DT = REMARRIED WIDOWER (5TH CLAIMANT)
                              DV = SURVIVING DIVORCED WIFE (3RD CLAIMANT)
                              DW = SURVIVING DIVORCED WIFE (4TH CLAIMANT)
                              DX = SURVIVING DIVORCED HUSBAND (4TH
                                   CLAIMANT)
                              DY = SURVIVING DIVORCED WIFE (5TH CLAIMANT)
                              DZ = SURVIVING DIVORCED HUSBAND (5TH
                                   CLAIMANT)
                              E  = MOTHER (WIDOW) (1ST CLAIMANT)
                              E1 = SURVIVING DIVORCED MOTHER (1ST
                                   CLAIMANT)
                              E2 = MOTHER (WIDOW) (2ND CLAIMANT)
                              E3 = SURVIVING DIVORCED MOTHER (2ND
                                   CLAIMANT)
                              E4 = FATHER (WIDOWER) (1ST CLAIMANT)
                              E5 = SURVIVING DIVORCED FATHER (WIDOWER)
                                    (1ST CLAIMANT)
                              E6 = FATHER (WIDOWER) (2ND CLAIMANT)
                              E7 = MOTHER (WIDOW) (3RD CLAIMANT)
                              E8 = MOTHER (WIDOW) (4TH CLAIMANT)
                              E9 = SURVIVING DIVORCED FATHER (WIDOWER)
                                    (2ND CLAIMANT)
                              EA = MOTHER (WIDOW) (5TH CLAIMANT)
                              EB = SURVIVING DIVORCED MOTHER (3RD
                                   CLAIMANT)
                              EC = SURVIVING DIVORCED MOTHER (4TH
                                   CLAIMANT)
                              ED = SURVIVING DIVORCED MOTHER (5TH
                                   CLAIMANT
                              EF = FATHER (WIDOWER) (3RD CLAIMANT)
```

```
                                 EG = FATHER (WIDOWER) (4TH CLAIMANT)
                                 EH = FATHER (WIDOWER) (5TH CLAIMANT)
                                 EJ = SURVIVING DIVORCED FATHER (3RD
                                      CLAIMANT)
                                 EK = SURVIVING DIVORCED FATHER (4TH
                                      CLAIMANT)
                                 EM = SURVIVING DIVORCED FATHER (5TH
                                      CLAIMANT)
                                 F1 = FATHER
                                 F2 = MOTHER
                                 F3 = STEPFATHER
                                 F4 = STEPMOTHER
                                 F5 = ADOPTING FATHER
                                 F6 = ADOPTING MOTHER
                                 F7 = SECOND ALLEGED FATHER
                                 F8 = SECOND ALLEGED MOTHER
                                 J1 = PRIMARY PROUTY ENTITLED TO HIB
                                      (LESS THAN 3 Q.C.) (GENERAL FUND)
                                 J2 = PRIMARY PROUTY ENTITLED TO HIB
                                      (OVER 2 Q.C.) (RSI TRUST FUND)
                                 J3 = PRIMARY PROUTY NOT ENTITLED TO HIB
                                      (LESS THAN 3 Q.C.) (GENERAL FUND)
                                 J4 = PRIMARY PROUTY NOT ENTITLED TO HIB
 1        BENE_IDENT_TB                    BENEFICIARY IDENTIFICATION CODE (BIC) TABLE
          -------------                    -------------------------------------------

                                      (OVER 2 Q.C.) (RSI TRUST FUND)
                                 K1 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
                                      3 Q.C.) (GENERAL FUND) (1ST CLAIMANT)
                                 K2 = PROUTY WIFE ENTITLED TO HIB (OVER 2
                                      Q.C.) (RSI TRUST FUND) (1ST CLAIMANT)
                                 K3 = PROUTY WIFE NOT ENTITLED TO HIB (LESS
                                      THAN 3 Q.C.) (GENERAL FUND) (1ST
                                      CLAIMANT)
                                 K4 = PROUTY WIFE NOT ENTITLED TO HIB (OVER
                                      2 Q.C.) (RSI TRUST FUND) (1ST
                                      CLAIMANT)
                                 K5 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
                                      3 Q.C.) (GENERAL FUND) (2ND CLAIMANT)
                                 K6 = PROUTY WIFE ENTITLED TO HIB (OVER 2
                                      Q.C.) (RSI TRUST FUND) (2ND CLAIMANT)
                                 K7 = PROUTY WIFE NOT ENTITLED TO HIB (LESS
                                      THAN 3 Q.C.) (GENERAL FUND) (2ND
                                      CLAIMANT)
```

```
                            K8 = PROUTY WIFE NOT ENTITLED TO HIB (OVER
                                 2 Q.C.) (RSI TRUST FUND) (2ND
                                 CLAIMANT)
                            K9 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
                                 3 Q.C.) (GENERAL FUND) (3RD CLAIMANT)
                            KA = PROUTY WIFE ENTITLED TO HIB (OVER 2
                                 Q.C.) (RSI TRUST FUND) (3RD CLAIMANT)
                            KB = PROUTY WIFE NOT ENTITLED TO HIB (LESS
                                 THAN 3 Q.C.) (GENERAL FUND) (3RD
                                 CLAIMANT)
                            KC = PROUTY WIFE NOT ENTITLED TO HIB (OVER
                                 2 Q.C.) (RSI TRUST FUND) (3RD
                                 CLAIMANT)
                            KD = PROUTY WIFE ENTITLED TO HIB (LESS THAN
                                 3 Q.C.) (GENERAL FUND) (4TH CLAIMANT)
                            KE = PROUTY WIFE ENTITLED TO HIB (OVER 2 Q.C
                                 (4TH CLAIMANT)
                            KF = PROUTY WIFE NOT ENTITLED TO HIB (LESS
                                 THAN 3 Q.C.)(4TH CLAIMANT)
                            KG = PROUTY WIFE NOT ENTITLED TO HIB (OVER
                                 2 Q.C.)(4TH CLAIMANT)
                            KH = PROUTY WIFE ENTITLED TO HIB (LESS THAN
                                 3 Q.C.)(5TH CLAIMANT)
                            KJ = PROUTY WIFE ENTITLED TO HIB (OVER 2
                                 Q.C.) (5TH CLAIMANT)
                            KL = PROUTY WIFE NOT ENTITLED TO HIB (LESS
                                 THAN 3 Q.C.)(5TH CLAIMANT)
                            KM = PROUTY WIFE NOT ENTITLED TO HIB (OVER
                                 2 Q.C.) (5TH CLAIMANT)
                            M  = UNINSURED-NOT QUALIFIED FOR DEEMED HIB
                            M1 = UNINSURED-QUALIFIED BUT REFUSED HIB
                            T  = UNINSURED-ENTITLED TO HIB UNDER DEEMED
                                 OR RENAL PROVISIONS
                            TA = MQGE (PRIMARY CLAIMANT)
                            TB = MQGE AGED SPOUSE (FIRST CLAIMANT)
                            TC = MQGE DISABLED ADULT CHILD (FIRST CLAIMANT)
                            TD = MQGE AGED WIDOW(ER) (FIRST CLAIMANT)
                            TE = MQGE YOUNG WIDOW(ER) (FIRST CLAIMANT)
                            TF = MQGE PARENT (MALE)
                            TG = MQGE AGED SPOUSE (SECOND CLAIMANT)
  1      BENE_IDENT_TB                BENEFICIARY IDENTIFICATION CODE (BIC) TABLE
         -------------                -------------------------------------------

                            TH = MQGE AGED SPOUSE (THIRD CLAIMANT)
```

```
                    TJ = MQGE AGED SPOUSE (FOURTH CLAIMANT)
                    TK = MQGE AGED SPOUSE (FIFTH CLAIMANT)
                    TL = MQGE AGED WIDOW(ER) (SECOND CLAIMANT)
                    TM = MQGE AGED WIDOW(ER) (THIRD CLAIMANT)
                    TN = MQGE AGED WIDOW(ER) (FOURTH CLAIMANT)
                    TP = MQGE AGED WIDOW(ER) (FIFTH CLAIMANT)
                    TQ = MQGE PARENT (FEMALE)
                    TR = MQGE YOUNG WIDOW(ER) (SECOND CLAIMANT)
                    TS = MQGE YOUNG WIDOW(ER) (THIRD CLAIMANT)
                    TT = MQGE YOUNG WIDOW(ER) (FOURTH CLAIMANT)
                    TU = MQGE YOUNG WIDOW(ER) (FIFTH CLAIMANT)
                    TV = MQGE DISABLED WIDOW(ER) FIFTH CLAIMANT
                    TW = MQGE DISABLED WIDOW(ER) FIRST CLAIMANT
                    TX = MQGE DISABLED WIDOW(ER) SECOND CLAIMANT
                    TY = MQGE DISABLED WIDOW(ER) THIRD CLAIMANT
                    TZ = MQGE DISABLED WIDOW(ER) FOURTH CLAIMANT
                    T2-T9 = DISABLED CHILD (SECOND TO NINTH
                            CLAIMANT)
                    W  = DISABLED WIDOW, AGE 50 OR OVER (1ST
                         CLAIMANT)
                    W1 = DISABLED WIDOWER, AGE 50 OR OVER (1ST
                         CLAIMANT)
                    W2 = DISABLED WIDOW (2ND CLAIMANT)
                    W3 = DISABLED WIDOWER (2ND CLAIMANT)
                    W4 = DISABLED WIDOW (3RD CLAIMANT)
                    W5 = DISABLED WIDOWER (3RD CLAIMANT)
                    W6 = DISABLED SURVIVING DIVORCED WIFE (1ST
                         CLAIMANT)
                    W7 = DISABLED SURVIVING DIVORCED WIFE (2ND
                         CLAIMANT)
                    W8 = DISABLED SURVIVING DIVORCED WIFE (3RD
                         CLAIMANT)
                    W9 = DISABLED WIDOW (4TH CLAIMANT)
                    WB = DISABLED WIDOWER (4TH CLAIMANT)
                    WC = DISABLED SURVIVING DIVORCED WIFE (4TH
                         CLAIMANT)
                    WF = DISABLED WIDOW (5TH CLAIMANT)
                    WG = DISABLED WIDOWER (5TH CLAIMANT)
                    WJ = DISABLED SURVIVING DIVORCED WIFE (5TH
                         CLAIMANT)
                    WR = DISABLED SURVIVING DIVORCED HUSBAND
                         (1ST CLAIMANT)
                    WT = DISABLED SURVIVING DIVORCED HUSBAND
                         (2ND CLAIMANT)
```

```
                              RAILROAD RETIREMENT BOARD:

                              NOTE:
                              EMPLOYEE:  A MEDICARE BENEFICIARY WHO IS
                                         STILL WORKING OR A WORKER WHO
                                         DIED BEFORE RETIREMENT
                              ANNUITANT: A PERSON WHO RETIRED UNDER THE
                                         RAILROAD RETIREMENT ACT ON OR
                                         AFTER 03/01/37
                              PENSIONER: A PERSON WHO RETIRED PRIOR TO
                                         03/01/37 AND WAS INCLUDED IN THE
                                         RAILROAD RETIREMENT ACT
1       BENE_IDENT_TB                 BENEFICIARY IDENTIFICATION CODE (BIC) TABLE
        -------------                 -------------------------------------------


                              10 = RETIREMENT - EMPLOYEE OR ANNUITANT
                              80 = RR PENSIONER (AGE OR DISABILITY)
                              14 = SPOUSE OF RR EMPLOYEE OR ANNUITANT
                                   (HUSBAND OR WIFE)
                              84 = SPOUSE OF RR PENSIONER
                              43 = CHILD OF RR EMPLOYEE
                              13 = CHILD OF RR ANNUITANT
                              17 = DISABLED ADULT CHILD OF RR ANNUITANT
                              46 = WIDOW/WIDOWER OF RR EMPLOYEE
                              16 = WIDOW/WIDOWER OF RR ANNUITANT
                              86 = WIDOW/WIDOWER OF RR PENSIONER
                              43 = WIDOW OF EMPLOYEE WITH A CHILD IN HER CARE
                              13 = WIDOW OF ANNUITANT WITH A CHILD IN HER CARE
                              83 = WIDOW OF PENSIONER WITH A CHILD IN HER CARE
                              45 = PARENT OF EMPLOYEE
                              15 = PARENT OF ANNUITANT
                              85 = PARENT OF PENSIONER
                              11 = SURVIVOR JOINT ANNUITANT
                                   (REDUCED BENEFITS TAKEN TO INSURE BENEFITS
                                   FOR SURVIVING SPOUSE)


1       BENE_PRMRY_PYR_TB                 BENEFICIARY PRIMARY PAYER TABLE
        -----------------                 -------------------------------



                              A = WORKING AGED BENE/SPOUSE WITH EMPLOYER
                                  GROUP HEALTH PLAN (EGHP)
```

```
                              B = END STAGE RENAL DISEASE (ESRD) BENEFICIARY
                                  IN THE 18 MONTH COORDINATION PERIOD WITH
                                  AN EMPLOYER GROUP HEALTH PLAN
                              C = CONDITIONAL PAYMENT BY MEDICARE; FUTURE
                                  REIMBURSEMENT EXPECTED
                              D = AUTOMOBILE NO-FAULT (EFF. 4/97; PRIOR
                                  TO 3/94, ALSO INCLUDED ANY LIABILITY
                                  INSURANCE)
                              E = WORKERS' COMPENSATION
                              F = PUBLIC HEALTH SERVICE OR OTHER FEDERAL
                                  AGENCY (OTHER THAN DEPT. OF VETERANS
                                  AFFAIRS)
                              G = WORKING DISABLED BENE (UNDER AGE 65
                                  WITH LGHP)
                              H = BLACK LUNG
                              I = DEPT. OF VETERANS AFFAIRS
                              J = ANY LIABILITY INSURANCE
                                  (EFF. 3/94 - 3/97)
                              L = ANY LIABILITY INSURANCE (EFF. 4/97)
                                  (EFF. 12/90 FOR CARRIER CLAIMS AND 10/93
                                  FOR FI CLAIMS; OBSOLETED FOR ALL CLAIM
                                  TYPES 7/1/96)

                              M = OVERRIDE CODE:  EGHP SERVICES INVOLVED
                                  (EFF. 12/90 FOR CARRIER CLAIMS AND 10/93
                                  FOR FI CLAIMS; OBSOLETED FOR ALL CLAIM
                                  TYPES 7/1/96)

                              N = OVERRIDE CODE:  NON-EGHP SERVICES INVOLVED
                                  (EFF. 12/90 FOR CARRIER CLAIMS AND 10/93
                                  FOR FI CLAIMS; OBSOLETED FOR ALL CLAIM
                                  TYPES 7/1/96)

                              BLANK = MEDICARE IS PRIMARY PAYER (NOT SURE
                                      OF EFFECTIVE DATE: IN USE 1/91, IF
                                      NOT EARLIER)

                              T = MSP COST AVOIDED - IEQ CONTRACTOR
                                  (EFF. 7/96 CARRIER CLAIMS ONLY)
                              U = MSP COST AVOIDED - HMO RATE CELL ADJUST-
                                  MENT CONTRACTOR (EFF. 7/96 CARRIER CLAIMS
                                  ONLY)
                              V = MSP COST AVOIDED - LITIGATION SETTLEMENT
                                  CONTRACTOR (EFF. 7/96 CARRIER CLAIMS
```

```
                                    ONLY)

                          X = MSP COST AVOIDED OVERRIDE CODE (EFF.
                              12/90 FOR CARRIER CLAIMS AND 10/93 FOR
                              FI CLAIMS; OBSOLETED FOR ALL CLAIM TYPES
                              7/1/96)

                                     ***PRIOR TO 12/90***

                          Y = OTHER SECONDARY PAYER INVESTIGATION
                              SHOWS MEDICARE AS PRIMARY PAYER
1       BENE_PRMRY_PYR_TB                   BENEFICIARY PRIMARY PAYER TABLE
        -----------------                   -------------------------------

                          Z = MEDICARE IS PRIMARY PAYER

                          NOTE:   VALUES C, M, N, Y, Z AND BLANK
                                  INDICATE MEDICARE IS PRIMARY PAYER.
                                  (VALUES Z AND Y WERE USED PRIOR TO
                                  12/90.  BLANK WAS SUPPOSE TO BE
                                  EFFECTIVE AFTER 12/90, BUT MAY HAVE
                                  BEEN USED PRIOR TO THAT DATE.)


1       BETOS_TB                                    BETOS TABLE
        --------                                    -----------


                          M1A = OFFICE VISITS - NEW
                          M1B = OFFICE VISITS - ESTABLISHED
                          M2A = HOSPITAL VISIT - INITIAL
                          M2B = HOSPITAL VISIT - SUBSEQUENT
                          M2C = HOSPITAL VISIT - CRITICAL CARE
                          M3  = EMERGENCY ROOM VISIT
                          M4A = HOME VISIT
                          M4B = NURSING HOME VISIT
                          M5A = SPECIALIST - PATHOLOGY
                          M5B = SPECIALIST - PSYCHIATRY
                          M5C = SPECIALIST - OPTHAMOLOGY
                          M5D = SPECIALIST - OTHER
                          M6  = CONSULTATIONS
                          P0  = ANESTHESIA
                          P1A = MAJOR PROCEDURE - BREAST
                          P1B = MAJOR PROCEDURE - COLECTOMY
                          P1C = MAJOR PROCEDURE - CHOLECYSTECTOMY
```

```
                                P1D = MAJOR PROCEDURE - TURP
                                P1E = MAJOR PROCEDURE - HYSTERCTOMY
                                P1F = MAJOR PROCEDURE - EXPLOR/DECOMPR/EXCISDISC
                                P1G = MAJOR PROCEDURE - OTHER
                                P2A = MAJOR PROCEDURE, CARDIOVASCULAR-CABG
                                P2B = MAJOR PROCEDURE, CARDIOVASCULAR-ANEURYSM REPAIR
                                P2C = MAJOR PROCEDURE, CARDIOVASCULAR-THROMBOENDARTERECTOMY
                                P2D = MAJOR PROCEDURE, CARDIOVASCUALR-CORONARY ANGIOPLASTY (PTCA)
                                P2E = MAJOR PROCEDURE, CARDIOVASCULAR-PACEMAKER INSERTION
                                P2F = MAJOR PROCEDURE, CARDIOVASCULAR-OTHER
                                P3A = MAJOR PROCEDURE, ORTHOPEDIC - HIP FRACTURE REPAIR
                                P3B = MAJOR PROCEDURE, ORTHOPEDIC - HIP REPLACEMENT
                                P3C = MAJOR PROCEDURE, ORTHOPEDIC - KNEE REPLACEMENT
                                P3D = MAJOR PROCEDURE, ORTHOPEDIC - OTHER
                                P4A = EYE PROCEDURE - CORNEAL TRANSPLANT
                                P4B = EYE PROCEDURE - CATARACT REMOVAL/LENS INSERTION
                                P4C = EYE PROCEDURE - RETINAL DETACHMENT
                                P4D = EYE PROCEDURE - TREATMENT
                                P4E = EYE PROCEDURE - OTHER
                                P5A = AMBULATORY PROCEDURES - SKIN
                                P5B = AMBULATORY PROCEDURES - MUSCULOSKELETAL
                                P5C = AMBULATORY PROCEDURES - INGUINAL HERNIA REPAIR
                                P5D = AMBULATORY PROCEDURES - LITHOTRIPSY
                                P5E = AMBULATORY PROCEDURES - OTHER
                                P6A = MINOR PROCEDURES - SKIN
                                P6B = MINOR PROCEDURES - MUSCULOSKELETAL
                                P6C = MINOR PROCEDURES - OTHER (MEDICARE FEE SCHEDULE)
                                P6D = MINOR PROCEDURES - OTHER (NON-MEDICARE FEE SCHEDULE)
                                P7A = ONCOLOGY - RADIATION THERAPY
                                P7B = ONCOLOGY - OTHER
                                P8A = ENDOSCOPY - ARTHROSCOPY
                                P8B = ENDOSCOPY - UPPER GASTROINTESTINAL
                                P8C = ENDOSCOPY - SIGMOIDOSCOPY
                                P8D = ENDOSCOPY - COLONOSCOPY
                                P8E = ENDOSCOPY - CYSTOSCOPY
                                P8F = ENDOSCOPY - BRONCHOSCOPY
                                P8G = ENDOSCOPY - LAPAROSCOPIC CHOLECYSTECTOMY
                                P8H = ENDOSCOPY - LARYNGOSCOPY
                                P8I = ENDOSCOPY - OTHER
                                P9A = DIALYSIS SERVICES
  1         BETOS_TB                                    BETOS TABLE
            --------                                    -----------

                                I1A = STANDARD IMAGING - CHEST
```

```
I1B = STANDARD IMAGING - MUSCULOSKELETAL
I1C = STANDARD IMAGING - BREAST
I1D = STANDARD IMAGING - CONTRAST GASTROINTESTINAL
I1E = STANDARD IMAGING - NUCLEAR MEDICINE
I1F = STANDARD IMAGING - OTHER
I2A = ADVANCED IMAGING - CAT: HEAD
I2B = ADVANCED IMAGING - CAT: OTHER
I2C = ADVANCED IMAGING - MRI: BRAIN
I2D = ADVANCED IMAGING - MRI: OTHER
I3A = ECHOGRAPHY - EYE
I3B = ECHOGRAPHY - ABDOMEN/PELVIS
I3C = ECHOGRAPHY - HEART
I3D = ECHOGRAPHY - CAROTID ARTERIES
I3E = ECHOGRAPHY - PROSTATE, TRANSRECTAL
I3F = ECHOGRAPHY - OTHER
I4A = IMAGING/PROCEDURE - HEART INCLUDING CARDIAC
                          CATHETER
I4B = IMAGING/PROCEDURE - OTHER
T1A = LAB TESTS - ROUTINE VENIPUNCTURE (NON MEDICARE
                  FEE SCHEDULE)
T1B = LAB TESTS - AUTOMATED GENERAL PROFILES
T1C = LAB TESTS - URINALYSIS
T1D = LAB TESTS - BLOOD COUNTS
T1E = LAB TESTS - GLUCOSE
T1F = LAB TESTS - BACTERIAL CULTURES
T1G = LAB TESTS - OTHER (MEDICARE FEE SCHEDULE)
T1H = LAB TESTS - OTHER (NON-MEDICARE FEE SCHEDULE)
T2A = OTHER TESTS - ELECTROCARDIOGRAMS
T2B = OTHER TESTS - CARDIOVASCULAR STRESS TESTS
T2C = OTHER TESTS - EKG MONITORING
T2D = OTHER TESTS - OTHER
D1A = MEDICAL/SURGICAL SUPPLIES
D1B = HOSPITAL BEDS
D1C = OXYGEN AND SUPPLIES
D1D = WHEELCHAIRS
D1E = OTHER DME
D1F = ORTHOTIC DEVICES
O1A = AMBULANCE
O1B = CHIROPRACTIC
O1C = ENTERAL AND PARENTERAL
O1D = CHEMOTHERAPY
O1E = OTHER DRUGS
O1F = VISION, HEARING AND SPEECH SERVICES
O1G = INFLUENZA IMMUNIZATION
```

```
                              Y1  = OTHER - MEDICARE FEE SCHEDULE
                              Y2  = OTHER - NON-MEDICARE FEE SCHEDULE
                              Z1  = LOCAL CODES
                              Z2  = UNDEFINED CODES
```

```
1      CARR_CLM_PMT_DNL_TB                        CARRIER CLAIM PAYMENT DENIAL TABLE
       -------------------                        ----------------------------------
```

```
                              0 = DENIED
                              1 = PHYSICIAN/SUPPLIER
                              2 = BENEFICIARY
                              3 = BOTH PHYSICIAN/SUPPLIER AND BENEFICIARY
                              4 = HOSPITAL (HOSPITAL BASED PHYSICIANS)
                              5 = BOTH HOSPITAL AND BENEFICIARY
                              6 = GROUP PRACTICE PREPAYMENT PLAN
                              7 = OTHER ENTRIES (E.G. EMPLOYER, UNION)
                              8 = FEDERALLY FUNDED
                              9 = PA SERVICE
                              A = BENEFICIARY UNDER LIMITATION OF
                                  LIABILITY
                              B = PHYSICIAN/SUPPLIER UNDER LIMITATION OF
                                  LIABILITY
                              D = DENIED DUE TO DEMONSTRATION INVOLVEMENT
                                  (EFF. 5/97)
                              E = MSP COST AVOIDED IRS/SSA/HCFA DATA
                                  MATCH (EFF. 7/3/00)
                              F = MSP COST AVOIDED HMO RATE CELL
                                  (EFF. 7/3/00)
                              G = MSP COST AVOIDED LITIGATION SETTLEMENT
                                  (EFF. 7/3/00)
                              H = MSP COST AVOIDED EMPLOYER VOLUNTARY
                                  REPORTING (EFF. 7/3/00)
                              J = MSP COST AVOIDED INSURER VOLUNTARY
                                  REPORTING (EFF. 7/3/00)
                              K = MSP COST AVOIDED INITIAL ENROLLMENT
                                  QUESTIONNAIRE (EFF. 7/3/00)
                              P = PHYSICIAN OWNERSHIP DENIAL (EFF 3/92)
                              Q = MSP COST AVOIDED - (CONTRACTOR #88888)
                                  VOLUNTARY AGREEMENT (EFF. 1/98)
                              T = MSP COST AVOIDED - IEQ CONTRACTOR
                                  (EFF. 7/96) (OBSOLETE 6/30/00)
                              U = MSP COST AVOIDED - HMO RATE CELL
                                  ADJUSTMENT (EFF. 7/96) (OBSOLETE 6/30/00)
```

```
                           V = MSP COST AVOIDED - LITIGATION
                               SETTLEMENT (EFF. 7/96) (OBSOLETE 6/30/00)
                           X = MSP COST AVOIDED - GENERIC
                           Y = MSP COST AVOIDED - IRS/SSA DATA
                               MATCH PROJECT (OBSOLETE 6/30/00)
```

```
 1   CARR_LINE_PRVDR_TYPE_TB                    CARRIER LINE PROVIDER TYPE TABLE
     ----------------------                     --------------------------------
```

```
                           FOR PHYSICIAN/SUPPLIER (RIC O) CLAIMS:

                           0 = CLINICS, GROUPS, ASSOCIATIONS,
                               PARTNERSHIPS, OR OTHER ENTITIES
                           1 = PHYSICIANS OR SUPPLIERS REPORTING AS
                               SOLO PRACTITIONERS
                           2 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
                           3 = INSTITUTIONAL PROVIDER
                           4 = INDEPENDENT LABORATORIES
                           5 = CLINICS (MULTIPLE SPECIALTIES)
                           6 = GROUPS (SINGLE SPECIALTY)
                           7 = OTHER ENTITIES

                           FOR DMERC (RIC M) CLAIMS - PRIOR TO VERSION H:

                           0 = CLINICS, GROUPS, ASSOCIATIONS,
                               PARTNERSHIPS, OR OTHER ENTITIES
                               FOR WHOM THE CARRIER'S OWN ID NUMBER
                               HAS BEEN ASSIGNED.
                           1 = PHYSICIANS OR SUPPLIERS BILLING AS
                               SOLO PRACTITIONERS FOR WHOM SSN'S ARE
                               SHOWN IN THE PHYSICIAN ID CODE FIELD.
                           2 = PHYSICIANS OR SUPPLIERS BILLING AS
                               SOLO PRACTITIONERS FOR WHOM THE CARRIER'S
                               OWN PHYSICIAN ID CODE IS SHOWN.
                           3 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
                               FOR WHOM EI NUMBERS ARE USED IN CODING THE
                               ID FIELD.
                           4 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
                               FOR WHOM THE CARRIER'S OWN CODE HAS BEEN
                               SHOWN.
                           5 = INSTITUTIONAL PROVIDERS AND
                               INDEPENDENT LABORATORIES FOR WHOM EI
                               NUMBERS ARE USED IN CODING THE ID FIELD.
```

```
                          6 = INSTITUTIONAL PROVIDERS AND
                              INDEPENDENT LABORATORIES FOR WHOM THE
                              CARRIER'S OWN ID NUMBER IS SHOWN.
                          7 = CLINICS, GROUPS, ASSOCIATIONS, OR
                              PARTNERSHIPS FOR WHOM EI NUMBERS
                              ARE USED IN CODING THE ID FIELD.
                          8 = OTHER ENTITIES FOR WHOM EI NUMBERS
                              ARE USED IN CODING THE ID FIELD OR
                              PROPRIETORSHIP FOR WHOM EI NUMBERS ARE
                              USED IN CODING THE ID FIELD.
```

```
 1CARR_LINE_RDCD_PHYSN_ASTNT_TB          CARRIER LINE PART B REDUCED PHYSICIAN ASSISTANT TABLE
  -----------------------------          ----------------------------------------------------
```

```
                          BLANK = ADJUSTMENT SITUATION (WHERE
                                  CLM_DISP_CD EQUAL 3)
                          0 = N/A
                          1 = 65%
                              A) PHYSICIAN ASSISTANTS ASSISTING IN
                                 SURGERY
                              B) NURSE MIDWIVES
                          2 = 75%
                              A) PHYSICIAN ASSISTANTS PERFORMING
                                 SERVICES IN A HOSPITAL (OTHER THAN
                                 ASSISTING SURGERY)
                              B) NURSE PRACTITIONERS AND CLINICAL
                                 NURSE SPECIALISTS PERFORMING
                                 SERVICES IN RURAL AREAS
                              C) CLINICAL SOCIAL WORKER SERVICES
                          3 = 85%
                              A) PHYSICIAN ASSISTANT SERVICES FOR
                                 OTHER THAN ASSISTING SURGERY
                              B) NURSE PRACTITIONERS SERVICES
```

```
 1          CARR_NUM_TB                             CARRIER NUMBER TABLE
            -----------                             --------------------
```

```
                          00510 = ALABAMA BS (EFF. 1983)
                          00511 = GEORGIA - ALABAMA BS (EFF. 1998)
                          00512 = MISSISSIPPI - ALABAMA BS (EFF. 2000)
                          00520 = ARKANSAS BS (EFF. 1983)
                          00521 = NEW MEXICO - ARKANSAS BS (EFF. 1998)
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00522 = OKLAHOMA - ARKANSAS BS (EFF. 1998)
00523 = MISSOURI - ARKANSAS BS (EFF. 1999)
00528 = LOUISIANNA - ARKANSAS BS (EFF. 1984)
00542 = CALIFORNIA BS (EFF. 1983; TERM. 1996)
00550 = COLORADO BS (EFF. 1983; TERM. 1994)
00570 = DELAWARE - PENNSYLVANIA BS (EFF. 1983;
          TERM. 1997)
00580 = DISTRICT OF COLUMBIA - PENNSYLVANIA BS
          (EFF. 1983; TERM. 1997)
00590 = FLORIDA BS (EFF. 1983)
00591 = CONNECTICUT - FLORIDA BS (EFF. 2000)
00621 = ILLINOIS BS - HCSC (EFF. 1983; TERM. 1998)
00623 = MICHIGAN - ILLINOIS BLUE SHIELD (EFF. 1995)
          (TERM. 1998)
00630 = INDIANA - ADMINISTAR (EFF. 1983)
00635 = DMERC-B (ADMINISTAR FEDERAL, INC.)
          (EFF. 1993)
00640 = IOWA - WELLMARK, INC. (EFF. 1983; TERM. 1998)
00645 = NEBRASKA - IOWA BS (EFF. 1985; TERM. 1987)
00650 = KANSAS BS (EFF. 1983)
00655 = NEBRASKA - KANSAS BS (EFF. 1988)
00660 = KENTUCKY - ADMINISTAR (EFF. 1983)
00690 = MARYLAND BS (EFF. 1983; TERM. 1994)
00700 = MASSACHUSETTS BS (EFF. 1983; TERM. 1997)
00710 = MICHIGAN BS (EFF. 1983; TERM. 1994)
00720 = MINNESOTA BS (EFF. 1983; TERM. 1995)
00740 = MISSOURI - BS KANSAS CITY (EFF. 1983)
00751 = MONTANA BS (EFF. 1983)
00770 = NEW HAMPSHIRE/VERMONT PHYSICIAN SERVICES
          (EFF. 1983; TERM. 1984)
00780 = NEW HAMPSHIRE/VERMONT - MASSACHUSETTS BS
          (EFF. 1985; TERM. 1997)
00801 = NEW YORK - WESTERN BS (EFF. 1983)
00803 = NEW YORK - EMPIRE BS (EFF. 1983)
00805 = NEW JERSEY - EMPIRE BS (EFF. 3/99)
00811 = DMERC (A) - WESTERN NEW YORK BS (EFF. 2000)
00820 = NORTH DAKOTA - NORTH DAKOTA BS (EFF. 1983)
00824 = COLORADO - NORTH DAKOTA BS (EFF. 1995)
00825 = WYOMING - NORTH DAKOTA BS (EFF. 1990)
00826 = IOWA - NORTH DAKOTA BS (EFF. 1999)
00831 = ALASKA - NORTH DAKOTA BS (EFF. 1998)
00832 = ARIZONA -  NORTH DAKOTA BS (EFF. 1998)
00833 = HAWAII - NORTH DAKOTA BS (EFF. 1998)
00834 = NEVADA - NORTH DAKOTA BS (EFF. 1998)
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                         00835 = OREGON - NORTH DAKOTA BS (EFF. 1998)
                         00836 = WASHINGTON - NORTH DAKOTA BS (EFF. 1998)
                         00860 = NEW JERSEY - PENNSYLVANIA BS (EFF. 1988;
                                 TERM. 1999)
                         00865 = PENNSYLVANIA BS (EFF. 1983)
                         00870 = RHODE ISLAND BS (EFF. 1983)
                         00880 = SOUTH CAROLINA BS (EFF. 1983)
                         00882 = RRB - SOUTH CAROLINA PGBA (EFF. 2000)
1          CARR_NUM_TB                          CARRIER NUMBER TABLE
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                         00885 = DMERC C - PALMETTO (EFF. 1993)
                         00900 = TEXAS BS (EFF. 1983)
                         00901 = MARYLAND - TEXAS BS (EFF. 1995)
                         00902 = DELAWARE - TEXAS BS (EFF. 1998)
                         00903 = DISTRICT OF COLUMBIA - TEXAS BS (EFF. 1998)
                         00904 = VIRGINIA - TEXAS BS (EFF. 2000)
                         00910 = UTAH  BS (EFF. 1983)
                         00951 = WISCONSIN - WISCONSIN PHY SVC (EFF. 1983)
                         00952 = ILLINOIS - WISCONSIN PHY SVC (EFF. 1999)
                         00953 = MICHIGAN - WISCONSIN PHY SVC (EFF. 1999)
                         00954 = MINNESOTA - WISCONSIN PHY SVC (EFF. 2000)
                         00973 = TRIPLE-S, INC. - PUERTO RICO (EFF. 1983)
                         00974 = TRIPLE-S, INC. - VIRGIN ISLANDS
                         01020 = ALASKA - AETNA (EFF. 1983; TERM. 1997)
                         01030 = ARIZONA - AETNA (EFF. 1983; TERM. 1997)
                         01040 = GEORGIA - AETNA (EFF. 1988; TERM. 1997)
                         01120 = HAWAII - AETNA (EFF. 1983; TERM. 1997)
                         01290 = NEVADA - AETNA (EFF. 1983; TERM. 1997)
                         01360 = NEW MEXICO - AETNA (EFF. 1986; TERM. 1997)
                         01370 = OKLAHOMA - AETNA (EFF. 1983; TERM. 1997)
                         01380 = OREGON - AETNA (EFF. 1983; TERM. 1997
                         01390 = WASHINGTON - AETNA (EFF. 1994; TERM. 1997)
                         02050 = CALIFORNIA - TOLIC (EFF. 1983)
                                 (TERM. 2000)
                         03070 = CONNECTICUT GENERAL LIFE INSURANCE CO.
                                 (EFF. 1983; TERM. 1985)
                         05130 = IDAHO - CONNECTICUT GENERAL (EFF. 1983)
                         05320 = NEW MEXICO - EQUITABLE INSURANCE
                                 (EFF. 1983; TERM. 1985)
                         05440 = TENNESSEE - CONNECTICUT GENERAL (EFF. 1983)
                         05530 = WYOMING - EQUITABLE INSURANCE (EFF. 1983)
                                 (TERM. 1989)
                         05535 = NORTH CAROLINA - CONNECTICUT GENERAL
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                                                  (EFF. 1988)
                                  05655 = DMERC-D - CONNECTICUT GENERAL (EFF. 1993)
                                  10071 = RAILROAD BOARD TRAVELERS (EFF. 1983)
                                          (TERM. 2000)
                                  10230 = CONNECTICUT - METRA HEALTH (EFF. 1986)
                                          (TERM. 2000)
                                  10240 = MINNESOTA - METRA HEALTH (EFF. 1983)
                                          (TERM. 2000)
                                  10250 = MISSISSIPPI - METRA HEALTH (EFF. 1983)
                                          (TERM. 2000)
                                  10490 = VIRGINIA - METRA HEALTH (EFF. 1983)
                                          (TERM. 2000)
                                  10555 = TRAVELERS INSURANCE CO. (EFF. 1993)
                                          (TERM. 2000)
                                  11260 = MISSOURI - GENERAL AMERICAN LIFE
                                          (EFF. 1983; TERM. 1998)
                                  14330 = NEW YORK - GHI (EFF. 1983)
                                  16360 = OHIO - NATIONWIDE INSURANCE CO.
                                  16510 = WEST VIRGINIA - NATIONWIDE INSURANCE CO.
                                  21200 = MAINE - BS OF MASSACHUSETTS
                                  31140 = CALIFORNIA - NATIONAL HERITAGE INS.
                                  31142 = MAINE - NATIONAL HERITAGE INS.
                                  31143 = MASSACHUSETTS - NATIONAL HERITAGE INS.
                                  31144 = NEW HAMPSHIRE - NATIONAL HERITAGE INS.
                                  31145 = VERMONT - NATIONAL HERITAGE INS.
1        CARR_NUM_TB                                 CARRIER NUMBER TABLE
         -----------                                 --------------------

                                  31146 = SO. CALIFORNIA - NHIC (EFF. 2000)


1        CLM_BILL_TYPE_TB                            CLAIM BILL TYPE TABLE
         ----------------                            --------------------


                                  11 = HOSPITAL-INPATIENT (INCLUDING PART A)
                                  12 = HOSPITAL-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
                                  13 = HOSPITAL-OUTPATIENT (HHA-A ALSO) (UNDER OPPS 13X
                                       MUST BE USED FOR ASC CLAIMS SUBMITTED FOR OPPS
                                       PAYMENT -- EFF. 7/00)
                                  14 = HOSPITAL-OTHER (PART B)
                                  15 = HOSPITAL-INTERMEDIATE CARE - LEVEL I
                                  16 = HOSPITAL-INTERMEDIATE CARE - LEVEL II
                                  17 = HOSPITAL-INTERMEDIATE CARE - LEVEL III
                                  18 = HOSPITAL-SWING BEDS
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19 = HOSPITAL-RESERVED FOR NATIONAL ASSIGNMENT
21 = SNF-INPATIENT (INCLUDING PART A)
22 = SNF-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
23 = SNF-OUTPATIENT (HHA-A ALSO)
24 = SNF-OTHER (PART B)
25 = SNF-INTERMEDIATE CARE - LEVEL I
26 = SNF-INTERMEDIATE CARE - LEVEL II
27 = SNF-INTERMEDIATE CARE - LEVEL III
28 = SNF-SWING BEDS
29 = SNF-RESERVED FOR NATIONAL ASSIGNMENT
31 = HHA-INPATIENT (INCLUDING PART A)
32 = HHA-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
33 = HHA-OUTPATIENT (HHA-A ALSO)
34 = HHA-OTHER (PART B)
35 = HHA-INTERMEDIATE CARE - LEVEL I
36 = HHA-INTERMEDIATE CARE - LEVEL II
37 = HHA-INTERMEDIATE CARE - LEVEL III
38 = HHA-SWING BEDS
39 = HHA-RESERVED FOR NATIONAL ASSIGNMENT
41 = RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (RNHCI)
     HOSPITAL-INPATIENT (INCLUDING PART A) (ALL REFERENCES
     TO CHRISTIAN SCIENCE (CS) IS OBSOLETE EFF. 8/00 AND
     REPLACED WITH RNHCI)
42 = RNHCI HOSPITAL-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
43 = RNHCI HOSPITAL-OUTPATIENT (HHA-A ALSO)
44 = RNHCI HOSPITAL-OTHER (PART B)
45 = RNHCI HOSPITAL-INTERMEDIATE CARE - LEVEL I
46 = RNHCI HOSPITAL-INTERMEDIATE CARE - LEVEL II
47 = RNHCI HOSPITAL-INTERMEDIATE CARE - LEVEL III
48 = RNHCI HOSPITAL-SWING BEDS
49 = RNHCI HOSPITAL-RESERVED FOR NATIONAL ASSIGNMENT
51 = CS EXTENDED CARE-INPATIENT (INCLUDING PART A) OBSOLETE
     EFF. 7/00 - IMPLEMENTATION OF RELIGIOUS NONMEDICAL
     HEALTH CARE INSTITUTIONS (RNHCI)
52 = RNHCI EXTENDED CARE-INPATIENT OR HOME HEALTH VISITS
     (PART B ONLY) (EFF. 7/00); PRIOR TO 7/00 CHRISTIAN SCIENCE (CS)
53 = RNHCI EXTENDED CARE-OUTPATIENT (HHA-A ALSO) (EFF. 7/00);
     PRIOR TO 7/00 REFERENCED CS
54 = RNHCI EXTENDED CARE-OTHER (PART B)(EFF. 7/00); PRIOR
     TO 7/00 REFERENCED CS
55 = RNHCI EXTENDED CARE-INTERMEDIATE CARE - LEVEL I (EFF. 7/00)
     PRIOR TO 7/00 REFERENCED CS
56 = RNHCI EXTENDED CARE-INTERMEDIATE CARE - LEVEL II (EFF. 7/00)
     PRIOR TO 7/00 REFERENCED CS
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                             57 = RNHCI EXTENDED CARE-INTERMEDIATE CARE - LEVEL III (EFF. 7/00)
                                  PRIOR TO 7/00 REFERENCED CS
                             58 = RNHCI EXTENDED CARE-SWING BEDS (EFF. 7/00)
1      CLM_BILL_TYPE_TB                        CLAIM BILL TYPE TABLE
       ----------------                        ---------------------

                                  PRIOR TO 7/00 REFERENCED CS
                             59 = RNHCI EXTENDED CARE-RESERVED FOR NATIONAL ASSIGNMENT
                                  (EFF. 7/00); PRIOR TO 7/00 REFERENCED CS
                             61 = INTERMEDIATE CARE-INPATIENT (INCLUDING PART A)
                             62 = INTERMEDIATE CARE-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
                             63 = INTERMEDIATE CARE-OUTPATIENT (HHA-A ALSO)
                             64 = INTERMEDIATE CARE-OTHER (PART B)
                             65 = INTERMEDIATE CARE-INTERMEDIATE CARE - LEVEL I
                             66 = INTERMEDIATE CARE-INTERMEDIATE CARE - LEVEL II
                             67 = INTERMEDIATE CARE-INTERMEDIATE CARE - LEVEL III
                             68 = INTERMEDIATE CARE-SWING BEDS
                             69 = INTERMEDIATE CARE-RESERVED FOR NATIONAL ASSIGNMENT
                             71 = CLINIC-RURAL HEALTH
                             72 = CLINIC-HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS FACILITY
                             73 = CLINIC-INDEPENDENT PROVIDER BASED FQHC (EFF 10/91)
                             74 = CLINIC-ORF ONLY (EFF 4/97);
                                  ORF AND CMHC (10/91 - 3/97)
                             75 = CLINIC-CORF
                             76 = CLINIC-CMHC (EFF 4/97)
                             77 = CLINIC-RESERVED FOR NATIONAL ASSIGNMENT
                             78 = CLINIC-RESERVED FOR NATIONAL ASSIGNMENT
                             79 = CLINIC-OTHER
                             81 = SPECIAL FACILITY OR ASC SURGERY-HOSPICE (NON-HOSPITAL BASED)
                             82 = SPECIAL FACILITY OR ASC SURGERY-HOSPICE (HOSPITAL BASED)
                             83 = SPECIAL FACILITY OR ASC SURGERY-AMBULATORY SURGICAL CENTER
                                   (DISCONTINUED FOR HOSPITALS SUBJECT TO OUTPATIENT PPS;
                                    HOSPITALS MUST USE 13X FOR ASC CLAIMS SUBMITTED FOR OPPS
                                    PAYMENT -- EFF. 7/00)
                             84 = SPECIAL FACILITY OR ASC SURGERY-FREESTANDING BIRTHING CENTER
                             85 = SPECIAL FACILITY OR ASC SURGERY-RURAL PRIMARY CARE HOSPITAL (EFF
                             86 = SPECIAL FACILITY OR ASC SURGERY-RESERVED FOR NATIONAL USE
                             87 = SPECIAL FACILITY OR ASC SURGERY-RESERVED FOR NATIONAL USE
                             88 = SPECIAL FACILITY OR ASC SURGERY-RESERVED FOR NATIONAL USE
                             89 = SPECIAL FACILITY OR ASC SURGERY-OTHER
                             91 = RESERVED-INPATIENT (INCLUDING PART A)
                             92 = RESERVED-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
                             93 = RESERVED-OUTPATIENT (HHA-A ALSO)
                             94 = RESERVED-OTHER (PART B)
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                              95 = RESERVED-INTERMEDIATE CARE - LEVEL I
                              96 = RESERVED-INTERMEDIATE CARE - LEVEL II
                              97 = RESERVED-INTERMEDIATE CARE - LEVEL III
                              98 = RESERVED-SWING BEDS
                              99 = RESERVED-RESERVED FOR NATIONAL ASSIGNMENT

1        CLM_DISP_TB                              CLAIM DISPOSITION TABLE
         -----------                              -----------------------


                              01 = DEBIT ACCEPTED
                              02 = DEBIT ACCEPTED (AUTOMATIC ADJUSTMENT)
                                   APPLICABLE THROUGH 4/4/93
                              03 = CANCEL ACCEPTED
                              61 = *CONVERSION CODE: DEBIT ACCEPTED
                              62 = *CONVERSION CODE: DEBIT ACCEPTED
                                    (AUTOMATIC ADJUSTMENT)
                              63 = *CONVERSION CODE: CANCEL ACCEPTED

                                *USED ONLY DURING CONVERSION PERIOD:
                                     1/1/91 - 2/21/91

1        CLM_FAC_TYPE_TB                          CLAIM FACILITY TYPE TABLE
         ---------------                          -------------------------


                              1 = HOSPITAL
                              2 = SKILLED NURSING FACILITY (SNF)
                              3 = HOME HEALTH AGENCY (HHA)
                              4 = RELIGIOUS NONMEDICAL (HOSPITAL)
                                  (EFF. 8/1/00); PRIOR TO 8/00 REFERENCED CHRISTIAN
                                  SCIENCE (CS)
                              5 = RELIGIOUS NONMEDICAL (EXTENDED CARE)
                                  (EFF. 8/1/00); PRIOR TO 8/00 REFERENCED CS
                              6 = INTERMEDIATE CARE
                              7 = CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY
                              8 = SPECIAL FACILITY OR ASC SURGERY
                              9 = RESERVED

1        CLM_FREQ_TB                              CLAIM FREQUENCY TABLE
         -----------                              ---------------------


                              0 = NON-PAYMENT/ZERO CLAIMS
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1 = ADMIT THRU DISCHARGE CLAIM
2 = INTERIM - FIRST CLAIM
3 = INTERIM - CONTINUING CLAIM
4 = INTERIM - LAST CLAIM
5 = LATE CHARGE(S) ONLY CLAIM
6 = ADJUSTMENT OF PRIOR CLAIM
7 = REPLACEMENT OF PRIOR CLAIM;
    EFF 10/93, PROVIDER DEBIT
8 = VOID/CANCEL PRIOR CLAIM.
    EFF 10/93, PROVIDER CANCEL
9 = FINAL CLAIM -- USED IN AN HH PPS
    EPISODE TO INDICATE THE CLAIM
    SHOULD BE PROCESSED LIKE DEBIT/
    CREDIT ADJUSTMENT TO RAP (INITIAL
    CLAIM) (EFF. 10/00)
A = ADMISSION NOTICE - USED WHEN HOSPICE
    IS SUBMITTING THE HCFA-1450 AS AN
    ADMISSION NOTICE - HOSPICE NOE ONLY
B = HOSPICE TERMINATION/REVOCATION NOTICE
    - HOSPICE NOE ONLY  (EFF 9/93)
C = HOSPICE CHANGE OF PROVIDER NOTICE
    - HOSPICE NOE ONLY (EFF 9/93)
D = HOSPICE ELECTION VOID/CANCEL
    - HOSPICE NOE ONLY  (EFF 9/93)
E = HOSPICE CHANGE OF OWNERSHIP
    - HOSPICE NOE ONLY  (EFF 1/97)
F = BENEFICIARY INITIATED ADJUSTMENT
    (EFF 10/93)
G = CWF GENERATED ADJUSTMENT (EFF 10/93)
H = HCFA GENERATED ADJUSTMENT (EFF 10/93)
I = MISC ADJUSTMENT CLAIM (OTHER THAN PRO
    OR PROVIDER) - USED TO IDENTIFY A
    DEBIT ADJUSTMENT INITIATED BY HCFA OR
    AN INTERMEDIARY - EFF 10/93, USED TO
    IDENTIFY INTERMEDIARY INITIATED
    ADJUSTMENT ONLY
J = OTHER ADJUSTMENT REQUEST (EFF 10/93)
K = OIG INITIATED ADJUSTMENT (EFF 10/93)
M = MSP ADJUSTMENT (EFF 10/93)
P = ADJUSTMENT REQUIRED BY PEER REVIEW
    ORGANIZATION (PRO)
X = SPECIAL ADJUSTMENT PROCESSING - USED
    FOR QA EDITING (EFF 8/92)
Z = HOSPITAL ENCOUNTER DATA ALTERNATE SUB-
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                                 MISSION (TOB '11Z') USED FOR MCO ENROLLEE
                                 HOSPITAL DISCHARGES 7/1/97-12/31/98; NOT
                                 STORED IN NCH.  EXCEPTION:  PROBLEM IN
                                 STARTUP MONTHS MAY HAVE RESULTED IN THIS
                                 ABBREVIATED UB-92 BEING ERRONEOUSLY
                                 STORED IN NCH.


1        CLM_HHA_RFRL_TB                      CLAIM HOME HEALTH REFERRAL TABLE
         ---------------                      --------------------------------


                                 1 = PHYSICIAN REFERRAL - THE PATIENT WAS
                                     ADMITTED UPON THE RECOMMENDATION OF
                                     A PERSONAL PHYSICIAN.
                                 2 = CLINIC REFERRAL - THE PATIENT WAS
                                     ADMITTED UPON THE RECOMMENDATION OF
                                     THIS FACILITY'S CLINIC PHYSICIAN.
                                 3 = HMO REFERRAL - THE PATIENT WAS ADMITTED
                                     UPON THE RECOMMENDATION OF AN HEALTH
                                     MAINTENANCE ORGANIZATION (HMO)
                                     PHYSICIAN.
                                 4 = TRANSFER FROM HOSPITAL - THE PATIENT
                                     WAS ADMITTED AS AN INPATIENT TRANSFER
                                     FROM AN ACUTE CARE FACILITY.
                                 5 = TRANSFER FROM A SKILLED NURSING
                                     FACILITY (SNF) - THE PATIENT WAS
                                     ADMITTED AS AN INPATIENT TRANSFER
                                     FROM A SNF.
                                 6 = TRANSFER FROM ANOTHER HEALTH CARE
                                     FACILITY - THE PATIENT WAS ADMITTED
                                     AS A TRANSFER FROM A HEALTH CARE
                                     FACILITY OTHER THAN AN ACUTE CARE
                                     FACILITY OR SNF.
                                 7 = EMERGENCY ROOM - THE PATIENT WAS
                                     ADMITTED UPON THE RECOMMENDATION OF
                                     THIS FACILITY'S EMERGENCY ROOM
                                     PHYSICIAN.
                                 8 = COURT/LAW ENFORCEMENT - THE PATIENT WAS
                                     ADMITTED UPON THE DIRECTION OF A
                                     COURT OF LAW OR UPON THE REQUEST OF
                                     A LAW ENFORCEMENT AGENCY'S
                                     REPRESENTATIVE.
                                 9 = INFORMATION NOT AVAILABLE -  THE MEANS
                                     BY WHICH THE PATIENT WAS ADMITTED IS
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                                    NOT KNOWN.
                             A = TRANSFER FROM A CRITICAL ACCESS HOSPITAL -
                                    PATIENT WAS ADMITTED/REFERRED TO THIS
                                    FACILITY AS A TRANSFER FROM A CRITICAL
                                    ACCESS HOSPITAL.
                             B = TRANSFER FROM ANOTHER HHA - BENEFICIARIES
                                    ARE PERMITTED TO TRANSFER FROM ONE HHA
                                    TO ANOTHER UNRELATED HHA UNDER HH PPS.
                                    (EFF. 10/00)
                             C = READMISSION TO SAME HHA - IF A BENEFICIARY
                                    IS DISCHARGED FROM AN HHA AND THEN RE-
                                    ADMITTED WITHIN THE ORIGINAL 60-DAY
                                    EPISODE, THE ORIGINAL EPISODE MUST BE
                                    CLOSED EARLY AND A NEW ONCE CREATED.
                                    NOTE: THE USE OF THIS CODE WILL PERMIT
                                    THE AGENCY TO SEND A NEW RAP ALLOWING
                                    ALL CLAIMS TO  BE ACCEPTED BY MEDICARE.
                                    (EFF. 10/00)

 1          CLM_HIPPS_TB                CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
            ------------                -------------------------------------------------


                             ******************  SNF PPS HIPPS *************************
                             **************1ST 3 POSITIONS (RUGS-III GROUP)**************
                             AAA = DEFAULT: NO ASSESSMENT

                             BA1,BA2,BB1,BB2 = BEHAVIOR ONLY PROBLEMS (E.G.,
                                               PHYSICAL/VERBAL ABUSE)

                             CA1,CA2,CB1,CB2 = CLINICALLY-COMPLEX CONDITIONS
                             CC1,CC2           (E.G., CHEMO, DIALYSIS)

                             IA1,IA2,IB1,IB2 = IMPAIRED COGNITION (E.G., IM-
                                               PAIRED COGNITION (E.G., SHORT-
                                               TERM MEMORY)

                             PA1,PA2,PB1,PB2 = REDUCED PHYSICAL FUNCTIONS
                             PC1,PC2,PD1,PD2
                             PE1,PE2

                             RHA,RHB,RHC,RLA = LOW/MEDIUM/HIGH REHABILITATION
                             RLB,RMA,RMB,RMC
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                              RUA,RUB,RUC,RVA = VERY HIGH/ULTRA HIGH REHABILITA-
                              RVB,RVC           TION: HIGHEST LEVEL

                              SE1,SE2,SE3     = EXTENSIVE SERVICES; E.G.; IV FEED
                                                TRACH CARE

                              SSA,SSB,SSC     = SPECIAL CARE; E.G.; COMA, BURNS

                              ***********POSITIONS 4 & 5 REPRESENT HIPPS MODIFIER/********
                              *************** ASSESSMENT TYPE INDICATOR *****************

                              00 = NO ASSESSMENT COMPLETED
                              01 = MEDICARE 5-DAY FULL ASSESSMENT/NOT AN INITIAL
                                     ADMISSION ASSESSMENT
                              02 = MEDICARE 30-DAY FULL ASSESSMENT
                              03 = MEDICARE 60-DAY FULL ASSESSMENT
                              04 = MEDICARE 90-DAY FULL ASSESSMENT
                              05 = MEDICARE READMISSION/RETURN REQUIRED ASSESSMENT
                                     (EFF. 10/2000)
                              07 = MEDICARE 14-DAY FULL OR COMPREHENSIVE ASSESSMENT/
                                     NOT AN INITIAL ADMISSION ASSESSMENT
                              08 = OFF-CYCLE OTHER MEDICARE REQUIRED ASSESSMENT (OMRA)
                              11 = ADMISSION ASSESSMENT AND MEDICARE 5-DAY (OR READMISSION/
                                     RETURN) ASSESSMENT
                              17 = MEDICARE 14-DAY REQUIRED ASSESSMENT AND INITIAL
                                     ADMISSION ASSESSMENT (EFF. 10/2000)
                              18 = OMRA REPLACING MEDICARE 5-DAY REQUIRED ASSESSMENT
                                     (EFF. 10/2000)
                              28 = OMRA REPLACING MEDICARE 30-DAY REQUIRED ASSESSMENT
                                     (EFF. 10/2000)
                              30 = OFF-CYCLE SIGNIFICANT CHANGE ASSESSMENT (OUTSIDE
                                     ASSESSMENT WINDOW) (EFF. 10/2000)
                              31 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
                                     5-DAY ASSESSMENT (EFF. 10/2000)
                              32 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
                                     30-DAY ASSESSMENT
1         CLM_HIPPS_TB                   CLAIM SNF & HHA HEALTH INSURANCE      PPS TABLE
          ------------                   -------------------------------------------------

                              33 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
                                     6--DAY ASSESSMENT
                              34 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
                                     90-DAY ASSESSMENT
                              35 = SIGNIFICANT CHANGE ASSESSMENT REPLACES A MEDICARE
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                          READMISSION/RETURN ASSESSMENT
          37 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
               14-DAY ASSESSMENT
          38 = OMRA REPLACING MEDICARE 60-DAY REQUIRED
               ASSESSMENT
          40 = OFF-CYCLE SIGNIFICANT CORRECTION ASSESSMENT OF A
               PRIOR ASSESSMENT (OUTSIDE ASSESSMENT WINDOW)
               (EFF. 10/2000)
          41 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
               REPLACES A MEDICARE 5-DAY ASSESSMENT
          42 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
               REPLACES A MEDICARE 30-DAY ASSESSMENT
          43 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
               REPLACES A MEDICARE 60-DAY ASSESSMENT
          44 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
               REPLACES A MEDICARE 90-DAY ASSESSMENT
          45 = SIGNIFICANT CORRECTION OF A PRIOR ASSESSMENT
               REPLACES A READMISSION/RETURN ASSESSMENT
               (EFF. 10/2000)
          47 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
               REPLACES A MEDICARE 14-DAY REQUIRED ASSESSMENT
          48 = OMRA REPLACING MEDICARE 90-DAY REQUIRED ASSESSMENT
          54 = QUARTERLY REVIEW ASSESSMENT - MEDICARE 90-DAY
               FULL ASSESSMENT
          78 = OMRA REPLACING A MEDICARE 14-DAY ASSESSMENT
               (EFF. 10/2000)


          **************************************************************
          **************************************************************



          *************CLAIM HOME HEALTH PPS HIPPS TABLE***************
          ********************** KEY ****************************
          POSITION 1 = 'H'
          POSITION 2 = CLINICAL (A, B, C, D)
          POSITION 3 = FUNCTIONAL (E, F, G, H, I)
          POSITION 4 = SERVICE (J, K, K, M)
          POSITION 5 = IDENTIFIES WHICH ELEMENTS OF THE CODE WERE
                       COMPUTED OR DERIVED:
                       1 = 2ND, 3RD, 4TH POSITIONS COMPUTED
                       2 = 2ND POSITION DERIVED
                       3 = 3RD POSITION DERIVED
                       4 = 4TH POSITION DERIVED
                       5 = 2ND & 3RD POSITIONS DERIVED
```

```
                              6 = 3RD & 4TH POSITIONS DERIVED
                              7 = 2ND & 4TH POSITIONS DERIVED
                              8 = 2ND, 3RD, 4TH POSITIONS DERIVED
                     ****************************************************************

                     **HHRG = C0F0S0/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = MIN**
                     HAEJ1
                     HAEJ2
                     HAEJ3
1          CLM_HIPPS_TB                 CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
           ------------                 --------------------------------------------------

                     HAEJ4
                     HAEJ5
                     HAEJ6
                     HAEJ7
                     HAEJ8
                     **HHRG = C0F0S1/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = LOW**
                     HAEK1
                     HAEK2
                     HAEK3
                     HAEK4
                     HAEK5
                     HAEK6
                     HAEK7
                     HAEK8
                     **HHRG = C0F0S2/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = MOD**
                     HAEL1
                     HAEL2
                     HAEL3
                     HAEL4
                     HAEL5
                     HAEL6
                     HAEL7
                     HAEL8
                     **HHRG = C0F0S3/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = HIGH**
                     HAEM1
                     HAEM2
                     HAEM3
                     HAEM4
                     HAEM5
                     HAEM6
                     HAEM7
                     HAEM8
```

```
                                   **HHRG = C0F1S0/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = MIN**
                                   HAFJ1
                                   HAFJ2
                                   HAFJ3
                                   HAFJ4
                                   HAFJ5
                                   HAFJ6
                                   HAFJ7
                                   HAFJ8
                                   **HHRG = C0F1S1/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = LOW**
                                   HAFK1
                                   HAFK2
                                   HAFK3
                                   HAFK4
                                   HAFK5
                                   HAFK6
                                   HAFK7
                                   HAFK8
                                   **HHRG = C0F1S2/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = MOD**
                                   HAFL1
                                   HAFL2
                                   HAFL3
                                   HAFL4
                                   HAFL5
                                   HAFL6
                                   HAFL7
 1          CLM_HIPPS_TB                  CLAIM SNF & HHA HEALTH INSURANCE         PPS TABLE
            ------------                  --------------------------------------------------

                                   HAFL8
                                   **HHRG = C0F1S3/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = HIGH**
                                   HAFM1
                                   HAFM2
                                   HAFM3
                                   HAFM4
                                   HAFM5
                                   HAFM6
                                   HAFM7
                                   HAFM8
                                   **HHRG = C0F2S0/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = MIN**
                                   HAGJ1
                                   HAGJ2
                                   HAGJ3
                                   HAGJ4
```

```
                              HAGJ5
                              HAGJ6
                              HAGJ7
                              HAGJ8
                              **HHRG = C0F2S1/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = LOW**
                              HAGK1
                              HAGK2
                              HAGK3
                              HAGK4
                              HAGK5
                              HAGK6
                              HAGK7
                              HAGK8
                              **HHRG = C0F2S2/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = MOD**
                              HAGL1
                              HAGL2
                              HAGL3
                              HAGL4
                              HAGL5
                              HAGL6
                              HAGL7
                              HAGL8
                              **HHRG = C0F2S3/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = HIGH**
                              HAGM1
                              HAGM2
                              HAGM3
                              HAGM4
                              HAGM5
                              HAGM6
                              HAGM7
                              HAGM8
                              **HHRG = C0F3S0/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = MIN**
                              HAHJ1
                              HAHJ2
                              HAHJ3
                              HAHJ4
                              HAHJ5
                              HAHJ6
                              HAHJ7
                              HAHJ8
                              **HHRG = C0F3S1/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = LOW**
                              HAHK1
                              HAHK2
 1        CLM_HIPPS_TB                CLAIM SNF & HHA HEALTH INSURANCE       PPS TABLE
```

```
            ------------                    -----------------------------------------------
                                HAHK3
                                HAHK4
                                HAHK5
                                HAHK6
                                HAHK7
                                HAHK8
                                **HHRG = C0F3S2/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = MOD**
                                HAHL1
                                HAHL2
                                HAHL3
                                HAHL4
                                HAHL5
                                HAHL6
                                HAHL7
                                HAHL8
                                **HHRG = C0F3S3/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = HIGH**
                                HAHM1
                                HAHM2
                                HAHM3
                                HAHM4
                                HAHM5
                                HAHM6
                                HAHM7
                                HAHM8
                                **HHRG = C0F4S0/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = MIN**
                                HAIJ1
                                HAIJ2
                                HAIJ3
                                HAIJ4
                                HAIJ5
                                HAIJ6
                                HAIJ7
                                HAIJ8
                                **HHRG = C0F4S1/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = LOW**
                                HAIK1
                                HAIK2
                                HAIK3
                                HAIK4
                                HAIK5
                                HAIK6
                                HAIK7
                                HAIK8
```

```
                                **HHRG = C0F4S2/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = MOD**
                                HAIL1
                                HAIL2
                                HAIL3
                                HAIL4
                                HAIL5
                                HAIL6
                                HAIL7
                                HAIL8
                                **HHRG = C0F4S3/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = HIGH**
                                HAIM1
                                HAIM2
                                HAIM3
                                HAIM4
                                HAIM5
                                HAIM6
   1        CLM_HIPPS_TB               CLAIM SNF & HHA HEALTH INSURANCE      PPS TABLE
            ------------               ------------------------------------------------

                                HAIM7
                                HAIM8
                                **HHRG = C1F0S0/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = MIN**
                                HBEJ1
                                HBEJ2
                                HBEJ3
                                HBEJ4
                                HBEJ5
                                HBEJ6
                                HBEJ7
                                HBEJ8
                                **HHRG = C1F0S1/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = LOW**
                                HBEK1
                                HBEK2
                                HBEK3
                                HBEK4
                                HBEK5
                                HBEK6
                                HBEK7
                                HBEK8
                                **HHRG = C1F0S2/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = MOD**
                                HBEL1
                                HBEL2
                                HBEL3
                                HBEL4
```

```
                              HBEL5
                              HBEL6
                              HBEL7
                              HBEL8
                              **HHRG = C1F0S3/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = HIGH**
                              HBEM1
                              HBEM2
                              HBEM3
                              HBEM4
                              HBEM5
                              HBEM6
                              HBEM7
                              HBEM8
                              **HHRG = C1F1S0/CLINICAL = LOW, FUNCTIONAL = LOW, SERVICE = MIN**
                              HBFJ1
                              HBFJ2
                              HBFJ3
                              HBFJ4
                              HBFJ5
                              HBFJ6
                              HBFJ7
                              HBFJ8
                              **HHRG = C1F1S1/CLINICAL = LOW, FUNCTIONAL = LOW, SERVICE = LOW**
                              HBFK1
                              HBFK2
                              HBFK3
                              HBFK4
                              HBFK5
                              HBFK6
                              HBFK7
                              HBFK8
                              **HHRG = C1F1S2/CLINICAL = LOW, FUNCTIONAL = LOW, SERVICE = MOD**
                              HBFL1
  1       CLM_HIPPS_TB                  CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
          ------------                  -------------------------------------------------

                              HBFL2
                              HBFL3
                              HBFL4
                              HBFL5
                              HBFL6
                              HBFL7
                              HBFL8
                              **HHRG = C1F1S3/CLINICAL = LOW, FUNCTIONAL = LOW, SERVICE = HIGH**
```

```
HBFM1
HBFM2
HBFM3
HBFM4
HBFM5
HBFM6
HBFM7
HBFM8
**HHRG = C1F2S0/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = MIN**
HBGJ1
HBGJ2
HBGJ3
HBGJ4
HBGJ5
HBGJ6
HBGJ7
HBGJ8
**HHRG = C1F2S1/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = LOW**
HBGK1
HBGK2
HBGK3
HBGK4
HBGK5
HBGK6
HBGK7
HBGK8
**HHRG = C1F2S2/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = MOD**
HBGL1
HBGL2
HBGL3
HBGL4
HBGL5
HBGL6
HBGL7
HBGL8
**HHRG = C1F2S3/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = HIGH**
HBGM1
HBGM2
HBGM3
HBGM4
HBGM5
HBGM6
HBGM7
HBGM8
```

```
                                        **HHRG = C1F3S0/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = MIN**
                                        HBHJ1
                                        HBHJ2
                                        HBHJ3
                                        HBHJ4
                                        HBHJ5
  1         CLM_HIPPS_TB                          CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
            ------------                          ------------------------------------------------

                                        HBHJ6
                                        HBHJ7
                                        HBHJ8
                                        **HHRG = C1F3S1/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = LOW**
                                        HBHK1
                                        HBHK2
                                        HBHK3
                                        HBHK4
                                        HBHK5
                                        HBHK6
                                        HBHK7
                                        HBHK8
                                        **HHRG = C1F3S2/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = MOD**
                                        HBHL1
                                        HBHL2
                                        HBHL3
                                        HBHL4
                                        HBHL5
                                        HBHL6
                                        HBHL7
                                        HBHL8
                                        **HHRG = C1F3S3/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = HIGH**
                                        HBHM1
                                        HBHM2
                                        HBHM3
                                        HBHM4
                                        HBHM5
                                        HBHM6
                                        HBHM7
                                        HBHM8
                                        **HHRG = C1F4S0/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = MIN**
                                        HBIJ1
                                        HBIJ2
                                        HBIJ3
                                        HBIJ4
```

```
                                   HBIJ5
                                   HBIJ6
                                   HBIJ7
                                   HBIJ8
                                   **HHRG = C1F4S1/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = LOW**
                                   HBIK1
                                   HBIK2
                                   HBIK3
                                   HBIK4
                                   HBIK5
                                   HBIK6
                                   HBIK7
                                   HBIK8
                                   **HHRG = C1F4S2/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = MOD**
                                   HBIL1
                                   HBIL2
                                   HBIL3
                                   HBIL4
                                   HBIL5
                                   HBIL6
                                   HBIL7
                                   HBIL8
                                   **HHRG = C1F4S3/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = HIGH**
   1        CLM_HIPPS_TB              CLAIM SNF & HHA HEALTH INSURANCE       PPS TABLE
            ------------             --------------------------------------------------

                                   HBIM1
                                   HBIM2
                                   HBIM3
                                   HBIM4
                                   HBIM5
                                   HBIM6
                                   HBIM7
                                   HBIM8
                                   **HHRG = C2F0S0/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = MIN**
                                   HCEJ1
                                   HCEJ2
                                   HCEJ3
                                   HCEJ4
                                   HCEJ5
                                   HCEJ6
                                   HCEJ7
                                   HCEJ8
                                   **HHRG = C2F0S1/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = LOW**
```

```
                              HCEK1
                              HCEK2
                              HCEK3
                              HCEK4
                              HCEK5
                              HCEK6
                              HCEK7
                              HCEK8
                              **HHRG = C2F0S2/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = MOD**
                              HCEL1
                              HCEL2
                              HCEL3
                              HCEL4
                              HCEL5
                              HCEL6
                              HCEL7
                              HCEL8
                              **HHRG = C2F0S3/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = HIGH**
                              HCEM1
                              HCEM2
                              HCEM3
                              HCEM4
                              HCEM5
                              HCEM6
                              HCEM7
                              HCEM8
                              **HHRG = C2F1S0/CLINICAL = MOD, FUNCTIONAL = LOW, SERVICE = MIN**
                              HCFJ1
                              HCFJ2
                              HCFJ3
                              HCFJ4
                              HCFJ5
                              HCFJ6
                              HCFJ7
                              HCFJ8
                              **HHRG = C2F1S2/CLINICAL = MOD, FUNCTIONAL = LOW, SERVICE = MOD**
                              HCFL1
                              HCFL2
                              HCFL3
                              HCFL4
 1       CLM_HIPPS_TB                 CLAIM SNF & HHA HEALTH INSURANCE       PPS TABLE
         ------------                 -------------------------------------------------

                              HCFL5
```

```
HCFL6
HCFL7
HCFL8
**HHRG = C2F1S3/CLINICAL = MOD, FUNCTIONAL = LOW, SERVICE = HIGH**
HCFM1
HCFM2
HCFM3
HCFM4
HCFM5
HCFM6
HCFM7
HCFM8
**HHRG = C2F2S0/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = MIN**
HCGJ1
HCGJ2
HCGJ3
HCGJ4
HCGJ5
HCGJ6
HCGJ7
HCGJ8
**HHRG = C2F2S1/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = LOW**
HCGK1
HCGK2
HCGK3
HCGK4
HCGK5
HCGK6
HCGK7
HCGK8
**HHRG = C2F2S2/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = MOD**
HCGL1
HCGL2
HCGL3
HCGL4
HCGL5
HCGL6
HCGL7
HCGL8
**HHRG = C2F2S3/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = HIGH**
HCGM1
HCGM2
HCGM3
HCGM4
```

```
                                         HCGM5
                                         HCGM6
                                         HCGM7
                                         HCGM8
                                         **HHRG = C2F3S0/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = MIN**
                                         HCHJ1
                                         HCHJ2
                                         HCHJ3
                                         HCHJ4
                                         HCHJ5
                                         HCHJ6
                                         HCHJ7
                                         HCHJ8
  1        CLM_HIPPS_TB                   CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
           ------------                   --------------------------------------------------

                                         **HHRG = C2F3S1/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = LOW**
                                         HCHK1
                                         HCHK2
                                         HCHK3
                                         HCHK4
                                         HCHK5
                                         HCHK6
                                         HCHK7
                                         HCHK8
                                         **HHRG = C2F3S2/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = MOD**
                                         HCHL1
                                         HCHL2
                                         HCHL3
                                         HCHL4
                                         HCHL5
                                         HCHL6
                                         HCHL7
                                         HCHL8
                                         **HHRG = C2F3S3/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = HIGH**
                                         HCHM1
                                         HCHM2
                                         HCHM3
                                         HCHM4
                                         HCHM5
                                         HCHM6
                                         HCHM7
                                         HCHM8
                                         **HHRG = C2F4S0/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = MIN**
```

```
                                  HCIJ1
                                  HCIJ2
                                  HCIJ3
                                  HCIJ4
                                  HCIJ5
                                  HCIJ6
                                  HCIJ7
                                  HCIJ8
                                  **HHRG = C2F4S1/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = LOW**
                                  HCIK1
                                  HCIK2
                                  HCIK3
                                  HCIK4
                                  HCIK5
                                  HCIK6
                                  HCIK7
                                  HCIK8
                                  **HHRG = C2F4S2/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = MOD**
                                  HCIL1
                                  HCIL2
                                  HCIL3
                                  HCIL4
                                  HCIL5
                                  HCIL6
                                  HCIL7
                                  HCIL8
                                  **HHRG = C2F4S3/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = HIGH**
                                  HCIM1
                                  HCIM2
                                  HCIM3
   1        CLM_HIPPS_TB                   CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
            ------------                   -------------------------------------------------

                                  HCIM4
                                  HCIM5
                                  HCIM6
                                  HCIM7
                                  HCIM8
                                  **HHRG = C3F0S0/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = MIN**
                                  HDEJ1
                                  HDEJ2
                                  HDEJ3
                                  HDEJ4
                                  HDEJ5
```

```
HDEJ6
HDEJ7
HDEJ8
**HHRG = C3F0S1/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = LOW**
HDEK1
HDEK2
HDEK3
HDEK4
HDEK5
HDEK6
HDEK7
HDEK8
**HHRG = C3F0S2/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = MOD**
HDEL1
HDEL2
HDEL3
HDEL4
HDEL5
HDEL6
HDEL7
HDEL8
**HHRG = C3F0S3/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = HIGH**
HDEM1
HDEM2
HDEM3
HDEM4
HDEM5
HDEM6
HDEM7
HDEM8
**HHRG = C3F1S0/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = MIN**
HDFJ1
HDFJ2
HDFJ3
HDFJ4
HDFJ5
HDFJ6
HDFJ7
HDFJ8
**HHRG = C3F1S1/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = LOW**
HDFK1
HDFK2
HDFK3
HDFK4
```

```
                                        HDFK5
                                        HDFK6
                                        HDFK7
 1          CLM_HIPPS_TB                 CLAIM SNF & HHA HEALTH INSURANCE        PPS TABLE
            ------------                 ------------------------------------------------

                                        HDFK8
                                        **HHRG = C3F1S2/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = MOD**
                                        HDFL1
                                        HDFL2
                                        HDFL3
                                        HDFL4
                                        HDFL5
                                        HDFL6
                                        HDFL7
                                        HDFL8
                                        **HHRG = C3F1S3/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = HIGH**
                                        HDFM1
                                        HDFM2
                                        HDFM3
                                        HDFM4
                                        HDFM5
                                        HDFM6
                                        HDFM7
                                        HDFM8
                                        **HHRG = C3F2S0/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = MIN**
                                        HDGJ1
                                        HDGJ2
                                        HDGJ3
                                        HDGJ4
                                        HDGJ5
                                        HDGJ6
                                        HDGJ7
                                        HDGJ8
                                        **HHRG = C3F2S1/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = LOW**
                                        HDGK1
                                        HDGK2
                                        HDGK3
                                        HDGK4
                                        HDGK5
                                        HDGK6
                                        HDGK7
                                        HDGK8
                                        **HHRG = C3F2S2/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = MOD**
```

```
                                         HDGL1
                                         HDGL2
                                         HDGL3
                                         HDGL4
                                         HDGL5
                                         HDGL6
                                         HDGL7
                                         HDGL8
                                         **HHRG = C3F2S3/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = HIGH**
                                         HDGM1
                                         HDGM2
                                         HDGM3
                                         HDGM4
                                         HDGM5
                                         HDGM6
                                         HDGM7
                                         HDGM8
                                         **HHRG = C3F3S0/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = MIN**
                                         HDHJ1
                                         HDHJ2
 1        CLM_HIPPS_TB                   CLAIM SNF & HHA HEALTH INSURANCE       PPS TABLE
          ------------                   -------------------------------------------------

                                         HDHJ3
                                         HDHJ4
                                         HDHJ5
                                         HDHJ6
                                         HDHJ7
                                         HDHJ8
                                         **HHRG = C3F3S1/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = LOW**
                                         HDHK1
                                         HDHK2
                                         HDHK3
                                         HDHK4
                                         HDHK5
                                         HDHK6
                                         HDHK7
                                         HDHK8
                                         **HHRG = C3F3S2/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = MOD**
                                         HDHL1
                                         HDHL2
                                         HDHL3
                                         HDHL4
                                         HDHL5
```

```
                                    HDHL6
                                    HDHL7
                                    HDHL8
                                    **HHRG = C3F3S3/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = HIGH**
                                    HDHM1
                                    HDHM2
                                    HDHM3
                                    HDHM4
                                    HDHM5
                                    HDHM6
                                    HDHM7
                                    HDHM8
                                    **HHRG = C3F4S0/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = MIN**
                                    HDIJ1
                                    HDIJ2
                                    HDIJ3
                                    HDIJ4
                                    HDIJ5
                                    HDIJ6
                                    HDIJ7
                                    HDIJ8
                                    **HHRG = C3F4S1/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = LOW**
                                    HDIK1
                                    HDIK2
                                    HDIK3
                                    HDIK4
                                    HDIK5
                                    HDIK6
                                    HDIK7
                                    HDIK8
                                    **HHRG = C3F4S2/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = MOD**
                                    HDIL1
                                    HDIL2
                                    HDIL3
                                    HDIL4
                                    HDIL5
                                    HDIL6
  1       CLM_HIPPS_TB             CLAIM SNF & HHA HEALTH INSURANCE      PPS TABLE
          ------------             --------------------------------------------------

                                    HDIL7
                                    HDIL8
                                    **HHRG = C3F4S3/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = HIGH**
                                    HDIM1
```

```
                                    HDIM2
                                    HDIM3
                                    HDIM4
                                    HDIM5
                                    HDIM6
                                    HDIM7
                                    HDIM8
```

```
1     CLM_IP_ADMSN_TYPE_TB                    CLAIM INPATIENT ADMISSION TYPE TABLE
      --------------------                    ------------------------------------


                                    0 = BLANK
                                    1 = EMERGENCY - THE PATIENT REQUIRED
                                        IMMEDIATE MEDICAL INTERVENTION AS A
                                        RESULT OF SEVERE, LIFE THREATENING, OR
                                        POTENTIALLY DISABLING CONDITIONS.
                                        GENERALLY, THE PATIENT WAS ADMITTED
                                        THROUGH THE EMERGENCY ROOM.
                                    2 = URGENT - THE PATIENT REQUIRED IMMEDIATE
                                        ATTENTION FOR THE CARE AND TREATMENT
                                        OF A PHYSICAL OR MENTAL DISORDER.
                                        GENERALLY, THE PATIENT WAS ADMITTED TO
                                        THE FIRST AVAILABLE AND SUITABLE
                                        ACCOMMODATION.
                                    3 = ELECTIVE - THE PATIENT'S CONDITION
                                        PERMITTED ADEQUATE TIME TO SCHEDULE THE
                                        AVAILABILITY OF SUITABLE ACCOMMODATIONS.
                                    4 = NEWBORN - NECESSITATES THE USE OF
                                        SPECIAL SOURCE OF ADMISSION CODES.

                                    5 THRU 8 =  RESERVED.
                                    9 =  UNKNOWN - INFORMATION NOT AVAILABLE.

1     CLM_MDCR_NPMT_RSN_TB                    CLAIM MEDICARE NON-PAYMENT REASON TABLE
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                                    A = COVERED WORKER'S COMPENSATION (OBSOLETE)
                                    B = BENEFIT EXHAUSTED
                                    C = CUSTODIAL CARE - NONCOVERED CARE
                                        (INCLUDES ALL 'BENEFICIARY AT FAULT'
                                        WAIVER CASES) (OBSOLETE)
                                    E = HMO OUT-OF-PLAN SERVICES NOT EMERGENCY
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                             OR URGENTLY NEEDED (OBSOLETE)
                        E = MSP COST AVOIDED - IRS/SSA/HCFA DATA
                             MATCH (EFF. 7/00)
                        F = MSP COST AVOID HMO RATE CELL (EFF. 7/00)
                        G = MSP COST AVOIDED LITIGATION SETTLEMENT
                             (EFF. 7/00)
                        H = MSP COST AVOIDED EMPLOYER VOLUNTARY
                             REPORTING (EFF. 7/00)
                        J = MSP COST AVOID INSURER VOLUNTARY
                             REPORTING (EFF. 7/00)
                        K = MSP COST AVOID INITIAL ENROLLMENT
                             QUESTIONNAIRE (EFF. 7/00)
                        N = ALL OTHER REASONS FOR NONPAYMENT
                        P = PAYMENT REQUESTED
                        Q = MSP COST AVOIDED VOLUNTARY AGREEMENT
                             (EFF. 7/00)
                        R = BENEFITS REFUSED, OR EVIDENCE NOT
                             SUBMITTED
                        T = MSP COST AVOIDED - IEQ CONTRACTOR
                             (EFF. 9/76) (OBSOLETE 6/30/00)
                        U = MSP COST AVOIDED - HMO RATE CELL
                             ADJUSTMENT (EFF. 9/76) (OBSOLETE 6/30/00)
                        V = MSP COST AVOIDED - LITIGATION
                             SETTLEMENT (EFF. 9/76) (OBSOLETE 6/30/00)
                        W = WORKER'S COMPENSATION (OBSOLETE)
                        X = MSP COST AVOIDED - GENERIC
                        Y = MSP COST AVOIDED - IRS/SSA DATA
                             MATCH PROJECT (OBSOLETE 6/30/00)
                        Z = ZERO REIMBURSEMENT RAPS -- ZERO REIMBURSEMENT
                             MADE DUE TO MEDICAL REVIEW INTERVENTION OR
                             WHERE PROVIDER SPECIFIC ZERO PAYMENT HAS BEEN
                             DETERMINED. (EFFECTIVE WITH HHPPS - 10/00)

1     CLM_OCRNC_SPAN_TB                         CLAIM OCCURRENCE SPAN TABLE
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                        70 = EFF 10/93, PAYER USE ONLY, THE
                             NONUTILIZATION FROM/THRU DATES
                             FOR PPS-INLIER STAY WHERE BENE HAD
                             EXHAUSTED ALL FULL/COINSURANCE DAYS, BUT
                             COVERED ON COST REPORT.
                             SNF QUALIFYING HOSPITAL STAY FROM/THRU DATES
                        71 = HOSPITAL PRIOR STAY DATES - THE FROM/
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                              THRU DATES OF ANY HOSPITAL STAY THAT
                              ENDED WITHIN 60 DAYS OF THIS HOSPITAL
                              OR SNF ADMISSION.
                     72 = FIRST/LAST VISIT - THE DATES OF THE
                              FIRST AND LAST VISITS OCCURRING IN THIS
                              BILLING PERIOD IF THE DATES ARE DIFFERENT
                              FROM THOSE IN THE STATEMENT COVERS PERIOD.
                     73 = BENEFIT ELIGIBILITY PERIOD - THE
                              INCLUSIVE DATES DURING WHICH CHAMPUS
                              MEDICAL BENEFITS ARE AVAILABLE TO A
                              SPONSOR'S BENE AS SHOWN ON THE
                              BENE'S ID CARD.
                     74 = NON-COVERED LEVEL OF CARE - THE FROM/
                              THRU DATES OF A PERIOD AT A NONCOVERED
                              LEVEL OF CARE IN AN OTHERWISE
                              COVERED STAY, EXCLUDING ANY PERIOD
                              REPORTED WITH OCCURRENCE SPAN CODE 76,
                              77, OR 79.
                     75 = THE FROM/THRU DATES OF SNF LEVEL OF CARE
                              DURING IP HOSPITAL STAY.  SHOWS PRO APPROVAL
                              OF PATIENT REMAINING IN HOSPITAL
                              BECAUSE SNF BED NOT AVAILABLE.
                              NOT APPLICABLE TO SWING BED
                              CASES. PPS HOSPITALS USE IN DAY
                              OUTLIER CASES ONLY.
                     76 = PATIENT LIABILITY - FROM/THRU
                              DATES OF PERIOD OF NONCOVERED CARE
                              FOR WHICH HOSPITAL MAY CHARGE
                              BENE. THE FI OR PRO MUST HAVE
                              APPROVED SUCH CHARGES IN ADVANCE.
                              PATIENT MUST BE NOTIFIED IN WRITING
                              3 DAYS PRIOR TO NONCOVERED PERIOD
                     77 = PROVIDER LIABILITY - THE FROM/THRU
                              DATES OF PERIOD OF NONCOVERED CARE
                              FOR WHICH THE PROVIDER IS LIABLE.
                              EFF 3/92, APPLIES TO PROVIDER LIABILITY
                              WHERE BENE IS CHARGED WITH UTILIZATION
                              AND IS LIABLE FOR DEDUCTIBLE/COINSURANCE
                     78 = SNF PRIOR STAY DATES - THE FROM/
                              THRU DATES OF ANY SNF STAY THAT
                              ENDED WITHIN 60 DAYS OF THIS HOSPITAL
                              OR SNF ADMISSION.
                     79 = (PAYER CODE) -
                              EFF 3/92, FROM/THRU DATES OF
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                                  PERIOD OF NONCOVERED CARE WHERE
                                  BENE IS NOT CHARGED WITH UTILIZATION,
                                  DEDUCTIBLE, OR COINSURANCE.
                                  AND PROVIDER IS LIABLE.
                                  EFF 9/93, NONCOVERED PERIOD OF CARE
                                  DUE TO LACK OF MEDICAL NECESSITY.
  1      CLM_OCRNC_SPAN_TB                      CLAIM OCCURRENCE SPAN TABLE
         -----------------                      ---------------------------

                         80 - 99 = RESERVED FOR STATE ASSIGNMENT
                         M0 = PRO/UR APPROVED STAY DATES - EFF 10/93,
                              THE FIRST AND LAST DAYS THAT WERE
                              APPROVED WHERE NOT ALL OF THE STAY WAS
                              APPROVED.

  1      CLM_OP_RFRL_TB                        CLAIM OUTPATIENT REFERRAL TABLE
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                          *  FOR OUTPATIENT CLAIMS:  EFFECTIVE 3/91 *

                         1 = PHYSICIAN REFERRAL - THE PATIENT WAS
                             REFERRED TO THIS FACILITY FOR OUTPATIENT
                             OR REFERENCED DIAGNOSTIC SERVICES
                             BY HIS OR HER PERSONAL PHYSICIAN
                             OR THE PATIENT INDEPENDENTLY REQUESTED
                             OUTPATIENT SERVICES.
                         2 = CLINICAL REFERRAL - THE PATIENT WAS
                             REFERRED TO THIS FACILITY FOR OUTPATIENT
                             OR REFERENCED DIAGNOSTIC SERVICES
                             BY THIS FACILITY'S CLINIC OR OTHER
                             OUTPATIENT DEPARTMENT PHYSICIAN
                         3 = HMO REFERRAL - THE PATIENT WAS REFERRED
                             TO THIS FACILITY FOR OUTPATIENT OR
                             REFERENCED DIAGNOSTIC SERVICES BY A
                             HMO PHYSICIAN.
                         4 = TRANSFER FROM A HOSPITAL - THE PATIENT
                             WAS REFERRED TO THIS FACILITY FOR
                             OUTPATIENT OR REFERENCED DIAGNOSTIC
                             SERVICES BY A PHYSICIAN OF ANOTHER
                             ACUTE CARE FACILITY.
                         5 = TRANSFER FROM A SNF - THE PATIENT WAS
                             REFERRED TO THIS FACILITY FOR OUTPATIENT
                             REFERENCED DIAGNOSTIC SERVICES
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                              BY A PHYSICIAN OF THE SNF WHERE
                              HE OR SHE IS AN INPATIENT.
                          6 = TRANSFER FROM ANOTHER HEALTH CARE
                              FACILITY - THE PATIENT WAS REFERRED TO
                              TO THIS FACILITY FOR OUTPATIENT OR
                              REFERENCED DIAGNOSTIC SERVICES BY A
                              PHYSICIAN OF ANOTHER HEALTH CARE
                              FACILITY WHERE HE OR SHE IS AN INPATIENT
                          7 = EMERGENCY ROOM - THE PATIENT WAS
                              REFERRED TO THIS FACILITY FOR
                              OUTPATIENT OR REFERENCED DIAGNOSTIC
                              SERVICES BY THIS FACILITY'S EMERGENCY
                              ROOM PHYSICIAN.
                          8 = COURT/LAW ENFORCEMENT - THE PATIENT WAS
                              REFERRED TO THIS FACILITY UPON THE
                              DIRECTION OF A COURT OF LAW, OR UPON
                              THE REQUEST OF A LAW ENFORCEMENT
                              AGENCY REPRESENTATIVE FOR OUTPATIENT
                              OR REFERENCED DIAGNOSTIC SERVICES.
                          9 = INFORMATION NOT AVAILABLE - FOR
                              MEDICARE OUTPATIENT CLAIMS THIS IS
                              NOT A VALID CODE.


   1     CLM_OP_SRVC_TYPE_TB                      CLAIM OUTPATIENT SERVICE TYPE TABLE
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                          0 = BLANK
                          1 = EMERGENCY - THE PATIENT REQUIRED
                              IMMEDIATE MEDICAL INTERVENTION AS A
                              RESULT OF SEVERE, LIFE THREATENING, OR
                              POTENTIALLY DISABLING CONDITIONS.
                              GENERALLY, THE PATIENT WAS ADMITTED
                              THROUGH THE EMERGENCY ROOM.
                          2 = URGENT - THE PATIENT REQUIRED IMMEDIATE
                              ATTENTION FOR THE CARE AND TREATMENT
                              OF A PHYSICAL OR MENTAL DISORDER.
                              GENERALLY, THE PATIENT WAS ADMITTED TO
                              THE FIRST AVAILABLE AND SUITABLE
                              ACCOMMODATION.
                          3 = ELECTIVE - THE PATIENT'S CONDITION
                              PERMITTED ADEQUATE TIME TO SCHEDULE THE
                              AVAILABILITY OF SUITABLE ACCOMMODATIONS.
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                                        5 THRU 8 =  RESERVED.
                                        9 =  UNKNOWN - INFORMATION NOT AVAILABLE.

1     CLM_OP_TRANS_TYPE_TB                        CLAIM OUTPATIENT TRANSACTION TYPE TABLE
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                                        A = OUTPATIENT PSYCHIATRIC HOSPITAL
                                        B = OUTPATIENT TB HOSPITAL
                                        C = OUTPATIENT GENERAL CARE HOSPITAL
                                        D = OUTPATIENT SNF
                                        E = HOME HEALTH AGENCY
                                        F = COMPREHENSIVE HEALTH CARE
                                        G = CLINICAL REHAB AGENCY
                                        H = RURAL HEALTH CLINIC
                                        I = SATELLITE DIALYSIS FACILITY
                                        J = LIMITED CARE FACILITY
                                        0 = CHRISTIAN SCIENCE SNF
                                        1 = PSYCHIATRIC HOSPITAL FACILITY
                                        2 = TB HOSPITAL FACILITY
                                        3 = GENERAL CARE HOSPITAL
                                        4 = REGULARY SNF
                                        SPACES = HOME HEALTH/HOSPICE

1     CLM_PPS_IND_TB                                 CLAIM PPS INDICATOR TABLE
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                                        ***EFFECTIVE NCH WEEKLY PROCESS DATE 10/3/97 - 5/29/98***

                                        0 = NOT PPS BILL (CLAIM CONTAINS NO PPS INDICATOR)
                                        2 = PPS BILL ( CLAIM CONTAINS PPS INDICATOR)

                                        ***EFFECTIVE NCH WEEKLY PROCESS DATE 6/5/98***

                                        0 = NOT APPLICABLE (CLAIM CONTAINS NEITHER PPS
                                            NOR DEEMED INSURED MQGE STATUS INDICATORS)
                                        1 = DEEMED INSURED MQGE (CLAIM CONTAINS DEEMED
                                            INSURED MQGE INDICATOR BUT NOT PPS INDICATOR)
                                        2 = PPS BILL ( CLAIM CONTAINS PPS INDICATOR BUT NO
                                            DEEMED INSURED MQGE STATUS INDICATOR)
                                        3 = BOTH PPS AND DEEMED INSURED MQGE (CONTAINS BOTH
                                            PPS AND DEEMED INSURED MQGE INDICATORS)
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1      CLM_RLT_COND_TB                              CLAIM RELATED CONDITION TABLE
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                               01 = MILITARY SERVICE RELATED - MEDICAL
                                    CONDITION INCURRED DURING MILITARY
                                    SERVICE.
                               02 = EMPLOYMENT RELATED - PATIENT ALLEGED
                                    THAT THE MEDICAL CONDITION CAUSING THIS
                                    EPISODE OF CARE WAS DUE TO ENVIRONMENT/
                                    EVENTS RESULTING FROM EMPLOYMENT.
                               03 = PATIENT COVERED BY INSURANCE NOT
                                    REFLECTED HERE - INDICATES THAT PATIENT
                                    OR PATIENT REPRESENTATIVE HAS STATED
                                    THAT COVERAGE MAY EXIST BEYOND THAT
                                    REFLECTED ON THIS BILL.
                               04 = HEALTH MAINTENANCE ORGANIZATION (HMO)
                                    ENROLLEE - MEDICARE BENEFICIARY IS
                                    ENROLLED IN AN HMO.  EFF 9/93, HOSPITAL
                                    MUST ALSO EXPECT TO RECEIVE PAYMENT
                                    FROM HMO.
                               05 = LIEN HAS BEEN FILED - PROVIDER HAS
                                    FILED LEGAL CLAIM FOR RECOVERY OF FUNDS
                                    POTENTIALLY DUE A PATIENT AS A RESULT
                                    OF LEGAL ACTION INITIATED BY OR ON
                                    BEHALF OF THE PATIENT.
                               06 = ESRD PATIENT IN 1ST 18 MONTHS OF ENTITLEMENT
                                    COVERED BY EMPLOYER GROUP HEALTH INSURANCE -
                                    INDICATES MEDICARE MAY BE SECONDARY
                                    INSURER.  EFF 3/1/96, ESRD PATIENT IN 1ST
                                    30 MONTHS OF ENTITLEMENT COVERED BY EMPLOYER
                                    GROUP HEALTH INSURANCE.
                               07 = TREATMENT OF NONTERMINAL CONDITION FOR
                                    HOSPICE PATIENT - THE PATIENT IS A
                                    HOSPICE ENROLLEE, BUT THE PROVIDER IS
                                    NOT TREATING A TERMINAL CONDITION AND
                                    IS REQUESTING MEDICARE REIMBURSEMENT.
                               08 = BENEFICIARY WOULD NOT PROVIDE INFORMATION
                                    CONCERNING OTHER INSURANCE COVERAGE.
                               09 = NEITHER PATIENT NOR SPOUSE IS EMPLOYED
                                    - CODE INDICATES THAT IN RESPONSE TO
                                    DEVELOPMENT QUESTIONS, THE PATIENT AND
                                    SPOUSE HAVE DENIED EMPLOYMENT.
                               10 = PATIENT AND/OR SPOUSE IS EMPLOYED BUT
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                                      NO EGHP COVERAGE EXISTS OR (EFF 9/93)
                                      OTHER EMPLOYER SPONSORED/PROVIDED
                                      HEALTH INSURANCE COVERING PATIENT.
                                 11 = THE DISABLED BENEFICIARY AND/OR FAMILY
                                      MEMBER HAS NO GROUP COVERAGE FROM A LGHP
                                      OR (EFF 9/93) OTHER EMPLOYER
                                      SPONSORED/PROVIDED HEALTH INSURANCE
                                      COVERING PATIENT.
                                 12 = PAYER CODE - RESERVED FOR INTERNAL
                                      USE ONLY BY THIRD PARTY PAYERS.  HCFA
                                      WILL ASSIGN AS NEEDED.  PROVIDERS WILL
                                      NOT REPORT THEM.
                                 13 = PAYER CODE - RESERVED FOR INTERNAL
                                      USE ONLY BY THIRD PARTY PAYERS.  HCFA
                                      WILL ASSIGN AS NEEDED.  PROVIDERS WILL
                                      NOT REPORT THEM.
                                 14 = PAYER CODE - RESERVED FOR INTERNAL
  1       CLM_RLT_COND_TB                    CLAIM RELATED CONDITION TABLE
          ---------------                    -----------------------------

                                      USE ONLY BY THIRD PARTY PAYERS.  HCFA
                                      WILL ASSIGN AS NEEDED.  PROVIDERS WILL
                                      NOT REPORT THEM.
                                 15 = CLEAN CLAIM (EFF 10/92)
                                 16 = SNF TRANSITION EXEMPTION - AN
                                      EXEMPTION FROM THE POST-HOSPITAL
                                      REQUIREMENT APPLIES FOR THIS SNF STAY
                                      OR THE QUALIFYING STAY DATES ARE MORE
                                      THAN 30 DAYS PRIOR TO THE ADMISSION DATE
                                 17 = PATIENT IS OVER 100 YEARS OLD - CODE
                                      INDICATES THAT THE PATIENT WAS OVER
                                      100 YEARS OLD AT THE DATE OF ADMISSION.
                                 18 = MAIDEN NAME RETAINED - A DEPENDENT
                                      SPOUSE ENTITLED TO BENEFITS WHO DOES
                                      NOT USE HER HUSBAND'S LAST NAME.
                                 19 = CHILD RETAINS MOTHER'S NAME - A
                                      PATIENT WHO IS A DEPENDENT CHILD
                                      ENTITLED TO CHAMPVA BENEFITS THAT DOES
                                      NOT HAVE FATHER'S LAST NAME.
                                 20 = BENE REQUESTED BILLING - PROVIDER
                                      REALIZES THE SERVICES ON THIS BILL ARE AT A
                                      NONCOVERED LEVEL OF CARE OR OTHERWISE EXCLUDED
                                      FROM COVERAGE, BUT THE BENE HAS REQUESTED
                                      FORMAL DETERMINATION
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                              21 = BILLING FOR DENIAL NOTICE - THE SNF OR HHA
                                   REALIZES SERVICES ARE AT A NONCOVERED LEVEL OF
                                   CARE OR EXCLUDED, BUT REQUESTS A MEDICARE DENIAL
                                   IN ORDER TO BILL MEDICAID OR OTHER INSURER
                              22 = PATIENT ON MULTIPLE DRUG REGIMEN - A
                                   PATIENT WHO IS RECEIVING MULTIPLE
                                   INTRAVENOUS DRUGS WHILE ON HOME IV
                                   THERAPY
                              23 = HOMECAREGIVER AVAILABLE - THE PATIENT
                                   HAS A CAREGIVER AVAILABLE TO ASSIST HIM
                                   OR HER DURING SELF-ADMINISTRATION OF AN
                                   INTRAVENOUS DRUG
                              24 = HOME IV PATIENT ALSO RECEIVING HHA
                                   SERVICES - THE PATIENT IS UNDER CARE
                                   OF HHA WHILE RECEIVING HOME IV DRUG
                                   THERAPY SERVICES
                              25 = RESERVED FOR NATIONAL ASSIGNMENT
                              26 = VA ELIGIBLE PATIENT CHOOSES TO
                                   RECEIVE SERVICES IN MEDICARE CERTIFIED
                                   FACILITY RATHER THAN A VA FACILITY
                                   (EFF 3/92)
                              27 = PATIENT REFERRED TO A SOLE COMMUNITY
                                   HOSPITAL FOR A DIAGNOSTIC LABORATORY
                                   TEST - (SOLE COMMUNITY HOSPITAL ONLY).
                                   (EFF 9/93)
                              28 = PATIENT AND/OR SPOUSE'S EGHP IS
                                   SECONDARY TO MEDICARE -
                                   QUALIFYING EGHP FOR EMPLOYERS WHO HAVE
                                   FEWER THAN 20 EMPLOYEES. (EFF 9/93)
                              29 = DISABLED BENEFICIARY AND/OR FAMILY
                                   MEMBER'S LGHP IS SECONDARY TO
                                   MEDICARE - QUALIFYING LGHP FOR
                                   EMPLOYER HAVING FEWER THAN 100 FULL AND
                                   PART-TIME EMPLOYEES
   1       CLM_RLT_COND_TB                       CLAIM RELATED CONDITION TABLE
           ---------------                       -----------------------------

                              31 = PATIENT IS STUDENT (FULL TIME - DAY) -
                                   PATIENT DECLARES THAT HE OR SHE IS
                                   ENROLLED AS A FULL TIME DAY STUDENT.
                              32 = PATIENT IS STUDENT (COOPERATIVE/WORK
                                   STUDY PROGRAM)
                              33 = PATIENT IS STUDENT (FULL TIME - NIGHT)
                                   - PATIENT DECLARES THAT HE OR SHE IS
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                              ENROLLED AS A FULL TIME NIGHT STUDENT.
                    34 = PATIENT IS STUDENT (PART TIME) -
                         PATIENT DECLARES THAT HE OR SHE IS
                         ENROLLED AS A PART TIME STUDENT.
                    36 = GENERAL CARE PATIENT IN A SPECIAL
                         UNIT - PATIENT IS TEMPORARILY PLACED IN
                         SPECIAL CARE UNIT BED BECAUSE NO
                         GENERAL CARE BEDS WERE AVAILABLE.
                    37 = WARD ACCOMMODATION IS PATIENT'S
                         REQUEST - PATIENT IS ASSIGNED TO WARD
                         ACCOMMODATIONS AT PATIENT'S REQUEST.
                    38 = SEMI-PRIVATE ROOM NOT AVAILABLE -
                         INDICATES THAT EITHER PRIVATE OR WARD
                         ACCOMMODATIONS WERE ASSIGNED BECAUSE
                         SEMI-PRIVATE ACCOMODATIONS WERE NOT
                         AVAILABLE.
                    39 = PRIVATE ROOM MEDICALLY NECESSARY -
                         PATIENT NEEDED A PRIVATE ROOM FOR
                         MEDICAL REASONS.
                    40 = SAME DAY TRANSFER - PATIENT
                         TRANSFERRED TO ANOTHER FACILITY
                         BEFORE MIDNIGHT OF THE DAY OF ADMISSION.
                    41 = PARTIAL HOSPITALIZATION - EFF 3/92,
                         INDICATES CLAIM IS FOR PARTIAL
                         HOSPITALIZATION SERVICES.  FOR OP
                         SERVICES, THIS INCLUDES A VARIETY
                         OF PSYCH PROGRAMS.
                    42 = RESERVED FOR NATIONAL ASSIGNMENT.
                    43 = RESERVED FOR NATIONAL ASSIGNMENT.
                    44 = RESERVED FOR NATIONAL ASSIGNMENT.
                    45 = RESERVED FOR NATIONAL ASSIGNMENT.
                    46 = NONAVAILABILITY STATEMENT ON FILE FOR
                         CHAMPUS CLAIM FOR NONEMERGENCY IP CARE
                         FOR CHAMPUS BENE RESIDING WITHIN THE
                         CATCHMENT AREA (USUALLY A 40 MILE
                         RADIUS) OF A UNIFORM SERVICES HOSPITAL.
                    47 = RESERVED FOR CHAMPUS.
                    48 = RESERVED FOR NATIONAL ASSIGNMENT.
                    49 = RESERVED FOR NATIONAL ASSIGNMENT.
                    50 = RESERVED FOR NATIONAL ASSIGNMENT.
                    51 = RESERVED FOR NATIONAL ASSIGNMENT.
                    52 = RESERVED FOR NATIONAL ASSIGNMENT.
                    53 = RESERVED FOR NATIONAL ASSIGNMENT.
                    54 = RESERVED FOR NATIONAL ASSIGNMENT.
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                                       55 = SNF BED NOT AVAILABLE - THE PATIENT'S
                                            SNF ADMISSION WAS DELAYED MORE THAN 30
                                            DAYS AFTER HOSPITAL DISCHARGE BECAUSE
                                            A SNF BED WAS NOT AVAILABLE.
                                       56 = MEDICAL APPROPRIATENESS - PATIENT'S
                                            SNF ADMISSION WAS DELAYED MORE THAN 30
                                            DAYS AFTER HOSPITAL DISCHARGE BECAUSE
    1        CLM_RLT_COND_TB                     CLAIM RELATED CONDITION TABLE
             ---------------                     -----------------------------

                                            PHYSICAL CONDITION MADE IT INAPPROPRIATE
                                            TO BEGIN ACTIVE CARE WITHIN THAT PERIOD
                                       57 = SNF READMISSION - PATIENT PREVIOUSLY
                                            RECEIVED MEDICARE COVERED SNF CARE
                                            WITHIN 30 DAYS OF THE CURRENT SNF
                                            ADMISSION.
                                       58 = PAYMENT OF SNF CLAIMS FOR BENEFICIARIES
                                            DISENROLLING FROM TERMINATING M+C PLANS
                                            PLANS WHO HAVE NOT MET THE 3-DAY HOSPITAL
                                            STAY REQUIREMENT (EFF. 10/1/00)
                                       59 = RESERVED FOR NATIONAL ASSIGNMENT.
                                       60 = OPERATING COST DAY OUTLIER - PRICER
                                            INDICATES THIS BILL IS LENGTH OF STAY
                                            OUTLIER (PPS)
                                       61 = OPERATING COST COST OUTLIER - PRICER
                                            INDICATES THIS BILL IS A COST OUTLIER
                                            (PPS)
                                       62 = PIP BILL - THIS BILL IS A PERIODIC
                                            INTERIM PAYMENT BILL.
                                       63 = PRO DENIAL RECEIVED BEFORE BATCH
                                            CLEARANCE REPORT - THE HCSSACL RECEIPT DATE
                                            IS USED ON PRO ADJUSTMENT IF THE PRO'S
                                            NOTIFICATION IS BEFORE ORIG BILL'S ACCEPTANCE
                                            REPORT. (PAYER ONLY CODE EFF 9/93)
                                       64 = OTHER THAN CLEAN CLAIM - THE CLAIM IS
                                            NOT A 'CLEAN CLAIM'
                                       65 = NON-PPS CODE - THE BILL IS NOT A
                                            PROSPECTIVE PAYMENT SYSTEM BILL.
                                       66 = OUTLIER NOT CLAIMED - BILL MAY MEET
                                            THE CRITERIA FOR COST OUTLIER, BUT THE
                                            HOSPITAL DID NOT CLAIM THE COST OUTLIER
                                            (PPS)
                                       67 = BENEFICIARY ELECTS NOT TO USE LTR DAYS
                                       68 = BENEFICIARY ELECTS TO USE LTR DAYS
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                            69 = OPERATING IME PAYMENT ONLY - PROVIDERS
                                 REQUEST FOR IME PAYMENT FOR EACH DISCHARGE
                                 OF MCO ENROLLEE, BEGINNING 1/1/98, FROM
                                 TEACHING HOSPITALS (FACILITIES WITH APPROVED
                                 MEDICAL RESIDENCY TRAINING PROGRAM); NOT
                                 STORED IN NCH.  EXCEPTION:  PROBLEM IN
                                 STARTUP YEAR MAY HAVE RESULTED IN THIS
                                 SPECIAL IME PAYMENT REQUEST BEING ERRONEOUSLY
                                 STORED IN NCH.  IF PRESENT, DISREGARD CLAIM
                                 AS CONDITION CODE '69' IS NOT VALID NCH
                                 CLAIM.
                            70 = SELF-ADMINISTERED EPO - BILLING IS
                                 FOR A HOME DIALYSIS PATIENT WHO SELF
                                 ADMINISTERS EPO.
                            71 = FULL CARE IN UNIT - BILLING IS FOR A
                                 PATIENT WHO RECEIVED STAFF ASSISTED
                                 DIALYSIS SERVICES IN A HOSPITAL OR
                                 RENAL DIALYSIS FACILITY.
                            72 = SELF CARE IN UNIT - BILLING IS FOR A
                                 PATIENT WHO MANAGED HIS OWN DIALYSIS
                                 SERVICES WITHOUT STAFF ASSISTANCE IN A
                                 HOSPITAL OR RENAL DIALYSIS FACILITY.
                            73 = SELF CARE TRAINING - BILLING IS FOR
                                 SPECIAL DIALYSIS SERVICES WHERE THE
1       CLM_RLT_COND_TB                         CLAIM RELATED CONDITION TABLE
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                                 PATIENT AND HELPER (IF NECESSARY) WERE
                                 LEARNING TO PERFORM DIALYSIS.
                            74 = HOME - BILLING IS FOR A PATIENT WHO
                                 RECEIVED DIALYSIS SERVICES AT HOME.
                            75 = HOME 100% REIMBURSEMENT -
                                  (NOT TO BE USED FOR SERVICES AFTER 4/15/90)
                                 THE BILLING IS FOR HOME DIALSIS PATIENT USING
                                 A DIALYSIS MACHINE THAT WAS PURCHASED
                                 UNDER THE 100% PROGRAM.
                            76 = BACK-UP FACILITY - BILLING IS FOR A
                                 PATIENT WHO RECEIVED DIALYSIS SERVICES
                                 IN A BACK-UP FACILITY.
                            77 = PROVIDER ACCEPTS OR IS OBLIGATED/
                                 REQUIRED DUE TO CONTRACTUAL AGREEMENT
                                 OR LAW TO ACCEPT PAYMENT BY A PRIMARY
                                 PAYER AS PAYMENT IN FULL - MEDICARE
                                 PAYS NOTHING.
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                              78 = NEW COVERAGE NOT IMPLEMENTED BY HMO -
                                   EFF 3/92, INDICATES NEWLY COVERED
                                   SERVICE UNDER MEDICARE FOR WHICH HMO
                                   DOES NOT PAY.
                              79 = CORF SERVICES PROVIDED OFF SITE -
                                   CODE INDICATES THAT PHYSICAL THERAPY,
                                   OCCUPATIONAL THERAPY, OR SPEECH PATH-
                                   OLOGY SERVICES WERE PROVIDED OFF SITE.
                              80 - 99 = RESERVED FOR STATE ASSIGNMENT.
                              A0 = CHAMPUS EXTERNAL PARTNERSHIP PROGRAM
                                   SPECIAL PROGRAM INDICATOR CODE. (EFF 10/93)
                              A1 = EPSDT/CHAP - EARLY AND PERIODIC
                                   SCREENING DIAGNOSIS AND TREATMENT
                                   SPECIAL PROGRAM INDICATOR CODE. (EFF 10/93)
                              A2 = PHYSICALLY HANDICAPPED CHILDREN'S
                                   PROGRAM - SERVICES PROVIDED RECEIVE
                                   SPECIAL FUNDING THROUGH TITLE 8 OF
                                   THE SOCIAL SECURITY ACT OR THE CHAMPUS
                                   PROGRAM FOR THE HANDICAPPED. (EFF 10/93)
                              A3 = SPECIAL FEDERAL FUNDING - DESIGNED FOR
                                   UNIFORM USE BY STATE UNIFORM BILLING
                                   COMMITTEES.
                                   SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                              A4 = FAMILY PLANNING - DESIGNED FOR
                                   UNIFORM USE BY STATE UNIFORM BILLING
                                   COMMITTEES.
                                   SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                              A5 = DISABILITY - DESIGNED FOR UNIFORM
                                   USE BY STATE UNIFORM BILLING
                                   COMMITTEES.
                                   SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                              A6 = PPV/MEDICARE - IDENTIFIES THAT
                                   PNEUMOCOCCAL PNEUMONIA 100% PAYMENT
                                   VACCINE (PPV) SERVICES SHOULD BE
                                   REIMBURSED UNDER A SPECIAL MEDICARE
                                   PROGRAM PROVISION.
                                   SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                              A7 = INDUCED ABORTION TO AVOID DANGER TO
                                   WOMAN'S LIFE.
                                   SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                              A8 = INDUCED ABORTION - VICTIM OF RAPE/
    1      CLM_RLT_COND_TB                         CLAIM RELATED CONDITION TABLE
           ---------------                         -----------------------------
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                                    INCEST.
                                    SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                            A9 = SECOND OPINION SURGERY - SERVICES
                                    REQUESTED TO SUPPORT SECOND OPINION
                                    ON SURGERY.  PART B DEDUCTIBLE AND
                                    COINSURANCE DO NOT APPLY.
                                    SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
                            B0 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B1 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B2 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B3 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B4 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B5 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B6 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B7 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B8 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            B9 = SPECIAL PROGRAM INDICATOR
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                            C0 = RESERVED FOR NATIONAL ASSIGNMENT.
                            C1 = APPROVED AS BILLED - THE SERVICES
                                    PROVIDED FOR THIS BILLING PERIOD HAVE
                                    BEEN REVIEWED BY THE PRO/UR OR
                                    INTERMEDIARY AND ARE FULLY APPROVED
                                    INCLUDING ANY DAY OR COST OUTLIER. (EFF 10/93)
                            C2 = AUTOMATIC APPROVAL AS BILLED BASED ON
                                    FOCUSED REVIEW.  (NO LONGER USED FOR
                                    MEDICARE)
                                    PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                            C3 = PARTIAL APPROVAL - THE SERVICES
                                    PROVIDED FOR THIS BILLING PERIOD HAVE
                                    BEEN REVIEWED BY THE PRO/UR OR
                                    INTERMEDIARY AND SOME PORTION HAS BEEN
                                    DENIED (DAYS OR SERVICES). (EFF 10/93)
                            C4 = ADMISSION/SERVICES DENIED - INDICATES
                                    THAT ALL OF THE SERVICES WERE DENIED
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                                          BY THE PRO/UR.
                                          PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                                   C5 = POSTPAYMENT REVIEW APPLICABLE - PRO/UR
                                          REVIEW TO TAKE PLACE AFTER PAYMENT.
                                          PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                                   C6 = ADMISSION PREAUTHORIZATION - THE
                                          PRO/UR AUTHORIZED THIS ADMISSION/
                                          SERVICE BUT HAS NOT REVIEWED THE
                                          SERVICES PROVIDED.
                                          PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                                   C7 = EXTENDED AUTHORIZATION - THE PRO HAS
                                          AUTHORIZED THESE SERVICES FOR AN
                                          EXTENDED LENGTH OF TIME BUT HAS NOT
                                          REVIEWED THE SERVICES PROVIDED.
 1        CLM_RLT_COND_TB                          CLAIM RELATED CONDITION TABLE
          ---------------                          -----------------------------

                                          PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                                   C8 = RESERVED FOR NATIONAL ASSIGNMENT.
                                          PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                                   C9 = RESERVED FOR NATIONAL ASSIGNMENT.
                                          PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
                                   D0 = CHANGES TO SERVICE DATES.
                                          CHANGE CONDITION (EFF 10/93)
                                   D1 = CHANGES IN CHARGES.
                                          CHANGE CONDITION (EFF 10/93)
                                   D2 = CHANGES IN REVENUE CODES/HCPCS.
                                          CHANGE CONDITION (EFF 10/93)
                                   D3 = SECOND OR SUBSEQUENT INTERIM
                                          PPS BILL.
                                          CHANGE CONDITION (EFF 10/93)
                                   D4 = CHANGE IN GROUPER INPUT (DIAGNOSIS
                                          AND/OR PROCEDURES ARE CHANGED RESULTING
                                          IN A DIFFERENT DRG).
                                          CHANGE CONDITION (EFF 10/93)
                                   D5 = CANCEL ONLY TO CORRECT A BENEFICIARY
                                          CLAIM ACCOUNT NUMBER OR PROVIDER
                                          IDENTIFICATION NUMBER.
                                          CHANGE CONDITION (EFF 10/93)
                                   D6 = CANCEL ONLY TO REPAY A DUPLICATE
                                          PAYMENT OR OIG OVERPAYMENT (INCLUDES
                                          CANCELLATION OF AN OP BILL CONTAINING
                                          SERVICES REQUIRED TO BE INCLUDED ON THE
                                          IP BILL). CHANGE CONDITION EFF 10/93.
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                              D7 = CHANGE TO MAKE MEDICARE THE SECONDARY
                                   PAYER.
                                   CHANGE CONDITION (EFF 10/93)
                              D8 = CHANGE TO MAKE MEDICARE THE PRIMARY
                                   PAYER.
                                   CHANGE CONDITION (EFF 10/93)
                              D9 = ANY OTHER CHANGE.
                                   CHANGE CONDITION (EFF 10/93)
                              E0 = CHANGE IN PATIENT STATUS.
                                   CHANGE CONDITION (EFF 10/93)
                              EY = NATIONAL EMPHYSEMA TREATMENT TRIAL (NETT)
                                   OR LUNG VOLUME REDUCTION SURGERY (LVRS)
                                   CLINICAL STUDY (EFF. 11/97)
                              G0 = MULTIPLE MEDICAL VISITS OCCUR ON THE SAME
                                   DAY IN THE SAME REVENUE CENTER BUT VISITS
                                   ARE DISTINCT AND CONSTITUTE INDEPENDENT
                                   VISITS (ALLOWS FOR PAYMENT UNDER OUTPATIENT
                                   PPS -- EFF. 7/3/00).
                              M0 = ALL INCLUSIVE RATE FOR OUTPATIENT SERVICES.
                                   (PAYER ONLY CODE)
                              M1 = ROSTER BILLED INFLUENZA VIRUS VACCINE.
                                   (PAYER ONLY CODE)
                                   EFF 10/96, ALSO INCLUDES PNEUMOCCOCAL
                                   PNEUMONIA VACCINE (PPV)
                              M2 = HH OVERRIDE CODE - HOME HEALTH TOTAL
                                   REIMBURSEMENT EXCEEDS THE $150,000 CAP
                                   OR THE NUMBER OF TOTAL VISITS EXCEEDS THE
                                   150 LIMITATION. (EFF 4/3/95)
                                   (PAYER ONLY CODE)
                              W0 = UNITED MINE WORKERS OF AMERICA (UMWA)
                                   SNF DEMONSTRATION INDICATOR (EFF 1/97);
1      CLM_RLT_COND_TB                        CLAIM RELATED CONDITION TABLE
       ---------------                        -----------------------------

                              BUT NO CLAIMS TRANSMITTED UNTIL 2/98)


1      CLM_RLT_OCRNC_TB                       CLAIM RELATED OCCURRENCE TABLE
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                              01 = AUTO ACCIDENT - THE DATE OF AN AUTO
                                   ACCIDENT.
                              02 = NO-FAULT INSURANCE INVOLVED, INCLUDING
                                   AUTO ACCIDENT/OTHER - THE DATE OF AN
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                     ACCIDENT WHERE THE STATE HAS APPLICABLE
                     NO-FAULT LIABILITY LAWS, (I.E., LEGAL
                     BASIS FOR SETTLEMENT WITHOUT ADMISSION
                     OR PROOF OF GUILT).
           03 = ACCIDENT/TORT LIABILITY - THE DATE OF
                     AN ACCIDENT RESULTING FROM A THIRD
                     PARTY'S ACTION THAT MAY INVOLVE A CIVIL
                     COURT PROCESS IN AN ATTEMPT TO REQUIRE
                     PAYMENT BY THE THIRD PARTY, OTHER THAN
                     NO-FAULT LIABILITY.
           04 = ACCIDENT/EMPLOYMENT RELATED - THE
                     DATE OF AN ACCIDENT RELATING TO THE
                     PATIENT'S EMPLOYMENT.
           05 = OTHER ACCIDENT - THE DATE OF AN ACCIDENT
                     NOT DESCRIBED BY THE CODES 01 THRU 04.
           06 = CRIME VICTIM - CODE INDICATING THE
                     DATE ON WHICH A MEDICAL CONDITION
                     RESULTED FROM ALLEGED CRIMINAL ACTION
                     COMMITTED BY ONE OR MORE PARTIES.
           07 = RESERVED FOR NATIONAL ASSIGNMENT.
           08 = RESERVED FOR NATIONAL ASSIGNMENT.
           11 = ONSET OF SYMPTOMS/ILLNESS - THE DATE
                     THE PATIENT FIRST BECAME AWARE OF
                     SYMPTOMS/ILLNESS.
           12 = DATE OF ONSET FOR A CHRONICALLY
                     DEPENDENT INDIVIDUAL - CODE INDICATES
                     THE DATE THE PATIENT/BENE BECAME
                     A CHRONICALLY DEPENDENT INDIVIDUAL.
           13 = RESERVED FOR NATIONAL ASSIGNMENT.
           14 = RESERVED FOR NATIONAL ASSIGNMENT.
           15 = RESERVED FOR NATIONAL ASSIGNMENT.
           16 = RESERVED FOR NATIONAL ASSIGNMENT.
           17 = DATE OUTPATIENT OCCUPATIONAL THERAPY
                     PLAN ESTABLISHED OR LAST REVIEWED -
                     CODE INDICATING THE DATE AN OCCUPATIONAL
                     THERAPY PLAN WAS ESTABLISHED OR
                     LAST REVIEWED (EFF 3/93)
           18 = DATE OF RETIREMENT (PATIENT/BENE)
                     - CODE INDICATES THE DATE OF RETIREMENT
                     FOR THE PATIENT/BENE.
           19 = DATE OF RETIREMENT SPOUSE -
                     CODE INDICATES THE DATE OF RETIREMENT
                     FOR THE PATIENT'S SPOUSE.
           20 = GUARANTEE OF PAYMENT BEGAN - THE DATE
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                                         ON WHICH THE PROVIDER BEGAN CLAIMING
                                         MEDICARE PAYMENT UNDER THE GUARANTEE
                                         OF PAYMENT PROVISION.
                                    21 = UR NOTICE RECEIVED - CODE INDICATING
                                         THE DATE OF RECEIPT BY THE HOSPITAL
                                         OF THE UR COMMITTEE'S FINDING THAT THE
                                         ADMISSION OR FUTURE STAY WAS NOT
                                         MEDICALLY NECESSARY.
                                    22 = ACTIVE CARE ENDED - THE DATE ON WHICH
  1        CLM_RLT_OCRNC_TB                         CLAIM RELATED OCCURRENCE TABLE
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                                         A COVERED LEVEL OF CARE ENDED IN A SNF
                                         OR GENERAL HOSPITAL, OR DATE ACTIVE CARE
                                         ENDED IN A PSYCHIATRIC OR TUBERCULOSIS
                                         HOSPITAL.   (FOR USE BY INTERMEDIARY ONLY)
                                    23 = RESERVED FOR NATIONAL ASSIGNMENT
                                         (EFF 10/93).
                                         BENEFITS EXHAUSTED - THE LAST DATE
                                         FOR WHICH BENEFITS CAN BE PAID.
                                         (TERM 9/30/93; REPLACED BY CODE A3)
                                    24 = DATE INSURANCE DENIED - THE DATE THE
                                         INSURER'S DENIAL OF COVERAGE WAS
                                         RECEIVED BY A HIGHER PRIORITY PAYER.
                                    25 = DATE BENEFITS TERMINATED BY PRIMARY
                                         PAYER - THE DATE ON WHICH COVERAGE
                                         (INCLUDING WORKER'S COMPENSATION BENEFITS
                                         OR NO-FAULT COVERAGE) IS NO LONGER
                                         AVAILABLE TO THE PATIENT.
                                    26 = DATE SKILLED NURSING FACILITY (SNF)
                                         BED AVAILABLE - THE DATE ON WHICH A SNF
                                         BED BECAME AVAILABLE TO A HOSPITAL
                                         INPATIENT WHO REQUIRED ONLY SNF LEVEL OF
                                         CARE.
                                    27 = DATE HOME HEALTH PLAN ESTABLISHED OR
                                         LAST REVIEWED - CODE INDICATING THE
                                         DATE A HOME HEALTH PLAN OF TREATMENT
                                         WAS ESTABLISHED OR LAST REVIEWED.
                                         NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
                                    28 = DATE COMPREHENSIVE OUTPATIENT REHABI-
                                         LITATION PLAN ESTABLISHED OR LAST RE-
                                         VIEWED - CODE INDICATING THE DATE A
                                         COMPREHENSIVE OUTPATIENT REHABILITATION
                                         PLAN WAS ESTABLISHED OR LAST REVIEWED.
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                                     NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
                               29 = DATE OPT PLAN ESTABLISHED OR LAST
                                    REVIEWED - THE DATE A PLAN OF TREATMENT
                                    WAS ESTABLISHED FOR OUTPATIENT PHYSICAL
                                    THERAPY.
                                    NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
                               30 = DATE SPEECH PATHOLOGY PLAN TREATMENT
                                    ESTABLISHED OR LAST REVIEWED - THE DATE
                                    A SPEECH PATHOLOGY PLAN OF TREATMENT
                                    WAS ESTABLISHED OR LAST REVIEWED.
                                    NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
                               31 = DATE BENE NOTIFIED OF INTENT
                                    TO BILL (ACCOMMODATIONS) - THE DATE OF
                                    THE NOTICE PROVIDED TO THE PATIENT BY
                                    THE HOSPITAL STATING THAT HE NO LONGER
                                    REQUIRED A COVERED LEVEL OF IP CARE.
                               32 = DATE BENE NOTIFIED OF INTENT
                                    TO BILL (PROCEDURES OR TREATMENT) - THE
                                    DATE OF THE NOTICE PROVIDED TO THE PATIENT
                                    BY THE HOSPITAL STATING REQUESTED CARE
                                    (DIAGNOSTIC PROCEDURES OR TREATMENTS) IS
                                    NOT CONSIDERED REASONABLE OR NECESSARY.
                               33 = FIRST DAY OF THE MEDICARE COORDINATION
                                    PERIOD FOR ESRD BENE - DURING
                                    WHICH MEDICARE BENEFITS ARE SECONDARY
                                    TO BENEFITS PAYABLE UNDER AN EGHP.
   1        CLM_RLT_OCRNC_TB                      CLAIM RELATED OCCURRENCE TABLE
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                                     REQUIRED ONLY FOR ESRD BENEFICIARIES.
                               34 = DATE OF ELECTION OF EXTENDED CARE
                                    FACILITIES - THE DATE THE GUEST ELECTED
                                    TO RECEIVE EXTENDED CARE SERVICES (USED
                                    BY CHRISTIAN SCIENCE SANATORIA ONLY).
                               35 = DATE TREATMENT STARTED FOR PHYSICAL
                                    THERAPY - CODE INDICATES THE DATE
                                    SERVICES WERE INITIATED BY THE BILLING
                                    PROVIDER FOR PHYSICAL THERAPY.
                               36 = DATE OF DISCHARGE FOR THE IP
                                    HOSPITAL STAY WHEN PATIENT
                                    RECEIVED A TRANSPLANT PROCEDURE
                                    - HOSPITAL IS BILLING FOR
                                    IMMUNOSUPPRESSIVE DRUGS.
                               37 = THE DATE OF DISCHARGE
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                              FOR THE IP HOSPITAL STAY WHEN
                              PATIENT RECEIVED A NONCOVERED
                              TRANSPLANT PROCEDURE - HOSPITAL
                              IS BILLING FOR IMMUNOSUPPRESIVE DRUGS.
                        38 = DATE TREATMENT STARTED FOR HOME IV
                              THERAPY - DATE THE PATIENT WAS FIRST
                              TREATED IN HIS HOME FOR IV THERAPY.
                        39 = DATE DISCHARGED ON A CONTINUOUS
                              COURSE OF IV THERAPY - DATE THE PATIENT
                              WAS DISCHARGED FROM THE HOSPITAL ON A
                              CONTINUOUS COURSE OF IV THERAPY.
                        40 = SCHEDULED DATE OF ADMISSION - THE
                              DATE ON WHICH A PATIENT WILL BE ADMITTED
                              AS AN INPATIENT TO THE HOSPITAL.
                              (THIS CODE MAY ONLY BE USED ON AN
                              OUTPATIENT CLAIM.)
                        41 = THE DATE ON WHICH THE FIRST
                              OUTPATIENT DIAGNOSTIC TEST WAS
                              PERFORMED AS PART OF A PRE-ADMISSION
                              TESTING (PAT) PROGRAM.  THIS CODE MAY
                              ONLY BE USED IF A DATE OF ADMISSION
                              WAS SCHEDULED PRIOR TO THE ADMINISTRATION
                              OF THE TEST(S).
                        42 = DATE OF DISCHARGE/TERMINATION OF HOSPICE
                              CARE - FOR THE FINAL BILL FOR HOSPICE
                              CARE.  EFF 5/93, DEFINITION REVISED TO
                              APPLY ONLY TO DATE PATIENT REVOKED
                              HOSPICE ELECTION.
                        43 = RESERVED FOR NATIONAL ASSIGNMENT.
                        44 = DATE TREATMENT STARTED FOR OCCUPATIONAL
                              THERAPY - CODE INDICATES THE DATE
                              SERVICES WERE INITIATED BY THE BILLING
                              PROVIDER FOR OCCUPATIONAL THERAPY.
                        45 = DATE TREATMENT STARTED FOR SPEECH
                              THERAPY - CODE INDICATES THE DATE
                              SERVICES WERE INITIATED BY THE BILLING
                              PROVIDER FOR SPEECH THERAPY.
                        46 = DATE TREATMENT STARTED FOR CARDIAC
                              REHABILITATION - CODE INDICATES THE
                              DATE SERVICES WERE INITIATED BY THE
                              BILLING PROVIDER FOR CARDIAC
                              REHABILITATION.
                        47 = NONCOVERED OUTLIER STAY BEGAN- CODE
      1        CLM_RLT_OCRNC_TB                        CLAIM RELATED OCCURRENCE TABLE
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                                  INDICATES THE DATE THAT COST OUTLIER
                                  STATUS BEGAN AND NO MEDICARE PAYMENT
                                  WILL BE MADE BECAUSE ALL BENEFITS HAVE
                                  BEEN EXHAUSTED DURING THE INLIER STAY OR
                                  THE BENEFICIARY DOES NOT ELECT TO USE LIFE
                                  TIME RESERVE DAYS (TO BE IMPLEMENTED IN
                                  1999).
                             48 = PAYER CODE - CODE RESERVED FOR
                                  INTERNAL USE ONLY BY THIRD PARTY
                                  PAYERS.  HCFA ASSIGNS AS NEEDED FOR
                                  YOUR USE.  PROVIDERS WILL NOT REPORT IT.
                             49 = PAYER CODE - CODE RESERVED FOR
                                  INTERNAL USE ONLY BY THIRD PARTY
                                  PAYERS.  HCFA ASSIGNS AS NEEDED FOR
                                  YOUR USE.  PROVIDERS WILL NOT REPORT IT.
                             50 - 69 = RESERVED FOR STATE ASSIGNMENT
                             A1 = BIRTHDATE, INSURED A - THE BIRTHDATE OF
                                  THE INDIVIDUAL IN WHOSE NAME THE INSURANCE
                                  IS CARRIED. (EFF 10/93)
                             A2 = EFFECTIVE DATE, INSURED A POLICY - A
                                  CODE INDICATING THE FIRST DATE INSURANCE
                                  IS IN FORCE. (EFF 10/93)
                             A3 = BENEFITS EXHAUSTED - CODE INDICATING
                                  THE LAST DATE FOR WHICH BENEFITS ARE
                                  AVAILABLE AND AFTER WHICH NO PAYMENT
                                  CAN BE MADE TO PAYER A.  (EFF 10/93)
                             B1 = BIRTHDATE, INSURED B - THE BIRTHDATE OF
                                  THE INDIVIDUAL IN WHOSE NAME THE INSURANCE
                                  IS CARRIED. (EFF 10/93)
                             B2 = EFFECTIVE DATE, INSURED B POLICY - A
                                  CODE INDICATING THE FIRST DATE INSURANCE
                                  IS IN FORCE. (EFF 10/93)
                             B3 = BENEFITS EXHAUSTED - CODE INDICATING
                                  THE LAST DATE FOR WHICH BENEFITS ARE
                                  AVAILABLE AND AFTER WHICH NO PAYMENT
                                  CAN BE MADE TO PAYER B.  (EFF 10/93)
                             C1 = BIRTHDATE, INSURED C - THE BIRTHDATE OF
                                  THE INDIVIDUAL IN WHOSE NAME THE INSURANCE
                                  IS CARRIED. (EFF 10/93)
                             C2 = EFFECTIVE DATE, INSURED C POLICY - A
                                  CODE INDICATING THE FIRST DATE INSURANCE
                                  IS IN FORCE. (EFF 10/93)
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                               C3 = BENEFITS EXHAUSTED - CODE INDICATING
                                    THE LAST DATE FOR WHICH BENEFITS ARE
                                    AVAILABLE AND AFTER WHICH NO PAYMENT
                                    CAN BE MADE TO PAYER C.  (EFF 10/93)

 1      CLM_SRC_IP_ADMSN_TB                       CLAIM SOURCE OF INPATIENT ADMISSION TABLE
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                                      **FOR INPATIENT/SNF CLAIMS:**


                               0 = ANOMALY: INVALID VALUE, IF PRESENT,
                                    TRANSLATE TO '9'
                               1 = PHYSICIAN REFERRAL - THE PATIENT WAS
                                    ADMITTED UPON THE RECOMMENDATION OF
                                    A PERSONAL PHYSICIAN.
                               2 = CLINIC REFERRAL - THE PATIENT WAS
                                    ADMITTED UPON THE RECOMMENDATION OF
                                    THIS FACILITY'S CLINIC PHYSICIAN.
                               3 = HMO REFERRAL - THE PATIENT WAS ADMITTED
                                    UPON THE RECOMMENDATION OF AN HEALTH
                                    MAINTENANCE ORGANIZATION (HMO)
                                    PHYSICIAN.
                               4 = TRANSFER FROM HOSPITAL - THE PATIENT
                                    WAS ADMITTED AS AN INPATIENT TRANSFER
                                    FROM AN ACUTE CARE FACILITY.
                               5 = TRANSFER FROM A SKILLED NURSING
                                    FACILITY (SNF) - THE PATIENT WAS
                                    ADMITTED AS AN INPATIENT TRANSFER
                                    FROM A SNF.
                               6 = TRANSFER FROM ANOTHER HEALTH CARE
                                    FACILITY - THE PATIENT WAS ADMITTED
                                    AS A TRANSFER FROM A HEALTH CARE
                                    FACILITY OTHER THAN AN ACUTE CARE
                                    FACILITY OR SNF.
                               7 = EMERGENCY ROOM - THE PATIENT WAS
                                    ADMITTED UPON THE RECOMMENDATION OF
                                    THIS FACILITY'S EMERGENCY ROOM
                                    PHYSICIAN.
                               8 = COURT/LAW ENFORCEMENT - THE PATIENT WAS
                                    ADMITTED UPON THE DIRECTION OF A
                                    COURT OF LAW OR UPON THE REQUEST OF
                                    A LAW ENFORCEMENT AGENCY'S
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                                    REPRESENTATIVE.
                       9 = INFORMATION NOT AVAILABLE -  THE MEANS
                           BY WHICH THE PATIENT WAS ADMITTED IS
                           NOT KNOWN.
                       A = TRANSFER FROM A CRITICAL ACCESS HOSPITAL -
                           PATIENT WAS ADMITTED/REFERRED TO THIS
                           FACILITY AS A TRANSFER FROM A CRITICAL
                           ACCESS HOSPITAL.
                           ----------------------------------------
                            **FOR NEWBORN TYPE OF ADMISSION**

                       1 = NORMAL DELIVERY - A BABY DELIVERED WITH
                           OUT COMPLICATIONS.
                       2 = PREMATURE DELIVERY - A BABY DELIVERED
                           WITH TIME AND/OR WEIGHT FACTORS
                           QUALIFYING IT FOR PREMATURE STATUS.
                       3 = SICK BABY - A BABY DELIVERED WITH
                           MEDICAL COMPLICATIONS, OTHER THAN THOSE
                           RELATING TO PREMATURE STATUS.
                       4 = EXTRAMURAL BIRTH - A BABY DELIVERED IN
                           A NONSTERILE ENVIRONMENT.
                       5-8 = RESERVED FOR NATIONAL ASSIGNMENT.
    1     CLM_SRC_IP_ADMSN_TB              CLAIM SOURCE OF INPATIENT ADMISSION TABLE
          --------------------            -----------------------------------------

                       9 = INFORMATION NOT AVAILABLE.


    1   CLM_SRVC_CLSFCTN_TYPE_TB          CLAIM SERVICE CLASSIFICATION TYPE TABLE
        ------------------------          ---------------------------------------


                         FOR FACILITY TYPE CODE 1 THRU 6, AND 9

                       1 = INPATIENT (INCLUDING PART A)
                       2 = HOSPITAL BASED OR INPATIENT (PART B ONLY)
                           OR HOME HEALTH VISITS UNDER PART B
                       3 = OUTPATIENT (HHA-A ALSO)
                       4 = OTHER (PART B)
                       5 = INTERMEDIATE CARE - LEVEL I
                       6 = INTERMEDIATE CARE - LEVEL II
                       7 = SUBACUTE INPATIENT
                           (FORMERLY INTERMEDIATE CARE - LEVEL III)
                       8 = SWING BEDS (USED TO INDICATE BILLING FOR
                           SNF LEVEL OF CARE IN A HOSPITAL WITH AN
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                                      APPROVED SWING BED AGREEMENT)
                              9 = RESERVED FOR NATIONAL ASSIGNMENT


                                FOR FACILITY TYPE CODE 7

                              1 = RURAL HEALTH
                              2 = HOSPITAL BASED OR INDEPENDENT RENAL
                                  DIALYSIS FACILITY
                              3 = FREE-STANDING PROVIDER BASED FEDERALLY
                                  QUALIFIED HEALTH CENTER (EFF 10/91)
                              4 = OTHER REHABILITATION FACILITY (ORF) AND
                                  COMMUNITY MENTAL HEALTH CENTER (CMHC)
                                  (EFF 10/91 - 3/97); ORF ONLY (EFF. 4/97)
                              5 = COMPREHENSIVE REHABILITATION CENTER
                                    (CORF)
                              6 = COMMUNITY MENTAL HEALTH CENTER (CMHC) (EFF 4/97)
                              7-8 = RESERVED FOR NATIONAL ASSIGNMENT
                              9 = OTHER


                                FOR FACILITY TYPE CODE 8

                              1 = HOSPICE (NON-HOSPITAL BASED)
                              2 = HOSPICE (HOSPITAL BASED)
                              3 = AMBULATORY SURGICAL CENTER IN HOSPITAL
                                  OUTPATIENT DEPARTMENT
                              4 = FREESTANDING BIRTHING CENTER
                              5 = CRITICAL ACCESS HOSPITAL (EFF. 10/99)
                                  FORMERLY RURAL PRIMARY CARE HOSPITAL
                                  (EFF. 10/94)
                              6-8 = RESERVED FOR NATIONAL USE
                              9 = OTHER
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    1         CLM_TRANS_TB                             CLAIM TRANSACTION TABLE
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                              0 = RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS (RNHCI)
                                  BILL (PRIOR TO 8/00, CHRISTIAN SCIENCE BILL), SNF BILL,
                                  OR STATE BUY-IN
                              1 = PSYCHIATRIC HOSPITAL FACILITY BILL OR DUMMY PSYCHIATRIC
                              2 = TUBERCULOSIS HOSPITAL FACILITY BILL
                              3 = GENERAL CARE HOSPITAL FACILITY BILL OR DUMMY LRD
                              4 = REGULAR SNF BILL
                              5 = HOME HEALTH AGENCY BILL (HHA)
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                               6 = OUTPATIENT HOSPITAL BILL
                               C = CORF BILL - TYPE OF OP BILL IN THE HHA BILL FORMAT
                                   (OBSOLETED 7/98)
                               H = HOSPICE BILL


   1         CLM_VAL_TB                              CLAIM VALUE TABLE
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                               04 = INPATIENT PROFESSIONAL COMPONENT
                                    CHARGES WHICH ARE COMBINED BILLED -
                                    FOR USE ONLY BY SOME ALL INCLUSIVE
                                    RATE HOSPITALS. (EFF 9/93)
                               05 = PROFESSIONAL COMPONENT INCLUDED IN
                                    CHARGES AND ALSO BILLED SEPARATELY TO
                                    CARRIER - FOR USE ON MEDICARE AND
                                    MEDICAID BILLS IF THE STATE REQUESTS
                                    THIS INFORMATION.
                               06 = MEDICARE BLOOD DEDUCTIBLE - TOTAL
                                    CASH BLOOD DEDUCTIBLE (PART A BLOOD
                                    DEDUCTIBLE).
                               07 = MEDICARE CASH DEDUCTIBLE (TERM 9/30/93)
                                    RESERVED FOR NATIONAL ASSIGNMENT.
                                    (EFF 10/93)
                               08 = MEDICARE PART A LIFETIME RESERVE AMOUNT
                                    IN FIRST CALENDAR YEAR - LIFETIME RESERVE
                                    AMOUNT CHARGED IN THE YEAR OF ADMISSION.
                                    (NOT STORED IN NCH UNTIL 2/93)
                               09 = MEDICARE PART A COINSURANCE AMOUNT IN
                                    THE FIRST CALENDAR YEAR - COINSURANCE
                                    AMOUNT CHARGED IN THE YEAR OF ADMISSION.
                                    (NOT STORED IN NCH UNTIL 2/93)
                               10 = MEDICARE PART A LIFETIME RESERVE AMOUNT
                                    IN THE SECOND CALENDAR YEAR - LIFETIME
                                    RESERVE AMOUNT CHARGED IN THE YEAR OF
                                    DISCHARGE WHERE THE BILL SPANS TWO
                                    CALENDAR YEARS.
                                    (NOT STORED IN NCH UNTIL 2/93)
                               11 = MEDICARE PART A COINSURANCE AMOUNT IN
                                    THE SECOND CALENDAR YEAR - COINSURANCE
                                    AMOUNT CHARGED IN THE YEAR OF DISCHARGE
                                    WHERE THE BILL SPANS TWO CALENDAR YEARS
                                    (NOT STORED IN NCH UNTIL 2/93)
                               12 = AMOUNT IS THAT PORTION OF
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                                          HIGHER PRIORITY EGHP INSURANCE PAYMENT
                                          MADE ON BEHALF OF AGED BENE
                                          PROVIDER APPLIED TO MEDICARE
                                          COVERED SERVICES ON THIS BILL.
                                          SIX ZEROES INDICATE PROVIDER
                                          CLAIMED CONDITIONAL MEDICARE PAYMENT.
                                    13 =  AMOUNT IS THAT PORTION OF HIGHER
                                          PRIORITY EGHP INSURANCE PAYMENT MADE ON
                                          BEHALF OF ESRD BENE PROVIDER
                                          APPLIED TO MEDICARE COVERED SERVICES
                                          ON THIS BILL. SIX ZEROES INDICATE
                                          THE PROVIDER CLAIMED CONDITIONAL
                                          MEDICARE PAYMENT.
                                    14 =  THAT PORTION OF PAYMENT FROM HIGHER
                                          PRIORITY NO FAULT AUTO/OTHER
                                          LIABILITY INSURANCE MADE ON BEHALF OF BENE
                                          PROVIDER APPLIED TO MEDICARE COVERED
                                          SERVICES ON THIS BILL. SIX ZEROES INDICATE
                                          PROVIDER CLAIMED CONDITIONAL PAYMENT
                                    15 =  THAT PORTION OF A PAYMENT FROM A
                                          HIGHER PRIORITY WC PLAN MADE ON BEHALF
                                          OF A BENE THAT THE PROVIDER APPLIED TO
  1        CLM_VAL_TB                             CLAIM VALUE TABLE
           ----------                             -----------------

                                          MEDICARE COVERED SERVICES ON THIS BILL. SIX
                                          ZEROES INDICATE THE PROVIDER CLAIMED
                                          CONDITIONAL MEDICARE PAYMENT.
                                    16 =  THAT PORTION OF A PAYMENT FROM
                                          HIGHER PRIORITY PHS OR OTHER FEDERAL
                                          AGENCY MADE ON BEHALF OF A
                                          BENE THE PROVIDER APPLIED
                                          TO MEDICARE COVERED SERVICES ON THIS
                                          BILL. SIX ZEROES INDICATE
                                          PROVIDER CLAIMED CONDITIONAL MEDICARE
                                          PAYMENT.
                                    17 =  OPERATING OUTLIER AMOUNT - PROVIDERS DO
                                          NOT REPORT THIS.  FOR PAYER INTERNAL USE
                                          ONLY.  INDICATES THE AMOUNT OF DAY OR
                                          COST OUTLIER PAYMENT TO BE MADE.
                                          (DO NOT INCLUDE ANY PPS CAPITAL OUTLIER
                                          PAYMENT IN THIS ENTRY).
                                    18 =  OPERATING DISPROPORTIONATE SHARE AMOUNT -
                                          PROVIDERS DO NOT REPORT THIS.  FOR
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                                PAYER INTERNAL USE ONLY.  INDICATES THE
                                DISPROPORTIONATE SHARE AMOUNT APPLICABLE
                                TO THE BILL.  USE THE AMOUNT PROVIDED BY
                                THE DISPROPORTIONATE SHARE FIELD IN PRICER.
                                (DO NOT INCLUDE ANY PPS CAPITAL DSH ADJUST-
                                MENT IN THIS ENTRY).
                           19 = OPERATING INDIRECT MEDICAL EDUCATION AMOUNT -
                                PROVIDERS DO NOT REPORT THIS.  FOR
                                PAYER INTERNAL USE ONLY.  INDICATES THE
                                INDIRECT MEDICAL EDUCATION AMOUNT APPLICABLE
                                TO THE BILL.  (DO NOT INCLUDE PPS CAPITAL
                                IME ADJUSTMENT IN THIS ENTRY).
                           20 = TOTAL PAYMENT SENT PROVIDER FOR CAPITAL
                                UNDER PPS, INCLUDING HSP, FSP, OUTLIER,
                                OLD CAPITAL, DSH ADJUSTMENT, IME
                                ADJUSTMENT, AND ANY EXCEPTION AMOUNT.
                                (USED 10/1/91 - 3/1/92 FOR PROVIDER
                                REPORTING.  PAYER ONLY CODE EFF 9/93.)
                           21 = CATASTROPHIC - MEDICAID - ELIGIBILITY
                                REQUIREMENTS TO BE DETERMINED AT STATE
                                LEVEL.  (MEDICAID SPECIFIC/DELETED 9/93)
                           22 = SURPLUS - MEDICAID - ELIGIBILITY
                                REQUIREMENTS TO BE DETERMINED AT STATE
                                LEVEL. (MEDICAID SPECIFIC/DELETED 9/93)
                           23 = RECURRING MONTHLY INCOME - MEDICAID -
                                ELIGIBILITY REQUIREMENTS TO BE
                                DETERMINED AT STATE LEVEL. (MEDICAID
                                SPECIFIC/DELETED 9/93)
                           24 = MEDICAID RATE CODE - MEDICAID -
                                ELIGIBILITY REQUIREMENTS TO BE
                                DETERMINED AT STATE LEVEL. (MEDICAID
                                SPECIFIC/DELETED 9/93)
                           31 = PATIENT LIABILITY AMOUNT - AMOUNT
                                SHOWN IS THAT WHICH YOU OR THE PRO
                                APPROVED TO CHARGE THE BENE FOR
                                NONCOVERED ACCOMMODATIONS, DIAGNOSTIC
                                PROCEDURES OR TREATMENTS.
                           37 = PINTS OF BLOOD FURNISHED - TOTAL
                                NUMBER OF PINTS OF WHOLE BLOOD OR UNITS
1         CLM_VAL_TB                             CLAIM VALUE TABLE
          ----------                             -----------------

                                OF PACKED RED CELLS FURNISHED TO THE
                                PATIENT. (EFF 10/93)
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38 = BLOOD DEDUCTIBLE PINTS - THE NUMBER
     OF UNREPLACED PINTS OF WHOLE BLOOD OR
     UNITS OF PACKED RED CELLS FURNISHED FOR
     WHICH THE PATIENT IS RESPONSIBLE.
     (EFF 10/93)
39 = PINTS OF BLOOD REPLACED - THE TOTAL
     NUMBER OF PINTS OF WHOLE BLOOD OR UNITS
     OF PACKED RED CELLS FURNISHED TO THE
     PATIENT THAT HAVE BEEN REPLACED BY OR
     ON BEHALF OF THE PATIENT. (EFF 10/93)
40 = NEW COVERAGE NOT IMPLEMENTED BY HMO -
     AMOUNT SHOWN IS FOR INPATIENT CHARGES
     COVERED BY HMO (EFF 3/92).
     (USE THIS CODE WHEN THE BILL INCLUDES
     INPATIENT CHARGES FOR NEWLY COVERED
     SERVICES WHICH ARE NOT PAID BY HMO.)
41 = AMOUNT IS THAT PORTION OF
     A PAYMENT FROM HIGHER PRIORITY BL
     PROGRAM MADE ON BEHALF OF
     BENE THE PROVIDER APPLIED
     TO MEDICARE COVERED SERVICES ON THIS
     BILL. SIX ZEROES INDICATE THE
     PROVIDER CLAIMED CONDITIONAL MEDICARE
     PAYMENT.
42 = AMOUNT IS THAT PORTION OF A PAYMENT
     FROM HIGHER PRIORITY VA MADE ON BEHALF
     OF BENE THE PROVIDER APPLIED
     TO MEDICARE COVERED SERVICES ON THIS
     BILL. SIX ZEROES INDICATE THE
     PROVIDER CLAIMED CONDITIONAL MEDICARE
     PAYMENT.
43 = DISABLED BENE UNDER AGE 65 WITH
     LGHP - AMOUNT IS THAT PORTION OF
     A PAYMENT FROM A HIGHER PRIORITY LGHP
     MADE ON BEHALF OF A DISABLED MEDICARE
     BENE THE PROVIDER APPLIED TO
     MEDICARE COVERED SERVICES ON THIS BILL.
44 = AMOUNT PROVIDER AGREED TO ACCEPT FROM
     PRIMARY PAYER WHEN AMOUNT LESS THAN CHARGES
     BUT MORE THAN PAYMENT RECEIVED -
     WHEN A LESSER AMOUNT IS RECEIVED AND THE
     RECEIVED AMOUNT IS LESS THAN CHARGES, A
     MEDICARE SECONDARY PAYMENT IS DUE.
46 = NUMBER OF GRACE DAYS - FOLLOWING THE
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                                        DATE OF THE PRO/UR DETERMINATION, THIS
                                        IS THE NUMBER OF DAYS DETERMINED BY THE
                                        PRO/UR TO BE NECESSARY TO ARRANGE FOR
                                        THE PATIENT'S POST-DISCHARGE CARE.
                                        (EFF 10/93)
                                   47 = ANY LIABILITY INSURANCE - AMOUNT
                                        IS THAT PORTION FROM A HIGHER PRIORITY
                                        LIABILITY INSURANCE MADE ON BEHALF OF
                                        MEDICARE BENE THE PROVIDER
                                        IS APPLYING TO MEDICARE COVERED
                                        SERVICES ON THIS BILL. (EFF 9/93)
                                   48 = HEMOGLOBIN READING - THE LATEST
1         CLM_VAL_TB                                  CLAIM VALUE TABLE
          ----------                                  -----------------


                                        HEMOGLOBIN READING TAKEN DURING THIS
                                        BILLING CYCLE.
                                   49 = LATEST HEMATOCRIT READING TAKEN
                                        DURING BILLING CYCLE - USUALLY
                                        REPORTED IN TWO POS. (A PERCENTAGE) TO
                                        LEFT OF THE DOLLAR/CENT DELIMITER.
                                        IF PROVIDED WITH A
                                        A DECIMAL, USE THE 3RD POS. TO RIGHT
                                        OF THE DELIMITER FOR THE THIRD DIGIT.
                                   50 = PHYSICAL THERAPY VISITS - INDICATES
                                        THE NUMBER OF PHYSICAL THERAPY
                                        VISITS FROM ONSET (AT BILLING PROVIDER)
                                        THROUGH THIS BILLING PERIOD.
                                   51 = OCCUPATIONAL THERAPY VISITS - INDICATES
                                        THE NUMBER OF OCCUPATIONAL THERAPY
                                        VISITS FROM ONSET (AT THE BILLING
                                        PROVIDER) THROUGH THIS BILLING PERIOD.
                                   52 = SPEECH THERAPY VISITS - INDICATES
                                        THE NUMBER OF SPEECH THERAPY
                                        VISITS FROM ONSET (AT BILLING PROVIDER)
                                        THROUGH THIS BILLING PERIOD.
                                   53 = CARDIAC REHABILITATION - INDICATES
                                        THE NUMBER OF CARDIAC REHABILITATION
                                        VISITS FROM ONSET (AT BILLING
                                        PROVIDER) THROUGH THIS BILLING PERIOD.
                                   54 = RESERVED FOR NATIONAL ASSIGNMENT.
                                   55 = RESERVED FOR NATIONAL ASSIGNMENT.
                                   56 = HOURS SKILLED NURSING PROVIDED - THE
                                        NUMBER OF HOURS SKILLED NURSING
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                                         PROVIDED DURING THE BILLING PERIOD.  COUNT
                                         ONLY HOURS SPENT IN THE HOME.
                                    57 = HOME HEALTH VISIT HOURS - THE NUMBER
                                         OF HOME HEALTH AIDE SERVICES PROVIDED
                                         DURING THE BILLING PERIOD.  COUNT ONLY
                                         THE HOURS SPENT IN THE HOME.
                                    58 = ARTERIAL BLOOD GAS - ARTERIAL BLOOD
                                         GAS VALUE AT BEGINNING OF EACH REPORTING
                                         PERIOD FOR OXYGEN THERAPY. THIS
                                         VALUE OR VALUE 59 WILL BE REQUIRED ON
                                         THE INITIAL BILL FOR OXYGEN THERAPY AND
                                         ON THE FOURTH MONTH'S BILL.
                                    59 = OXYGEN SATURATION - OXYGEN SATURATION
                                         AT THE BEGINNING OF EACH REPORTING
                                         PERIOD FOR OXYGEN THERAPY.  THIS VALUE OR
                                         VALUE 58 WILL BE REQUIRED ON THE
                                         INITIAL BILL FOR OXYGEN THERAPY AND ON
                                         THE FOURTH MONTH'S BILL.
                                    60 = HHA BRANCH MSA - MSA IN WHICH HHA
                                         BRANCH IS LOCATED.
                                    61 = LOCATION OF HHA SERVICE OR HOSPICE
                                         SERVICE - THE BALANCED BUDGET ACT
                                         (BBA) REQUIRES THAT THE GEOGRAPHIC
                                         LOCATION OF WHERE THE SERVICE WAS
                                         PROVIDED BE FURNISHED INSTEAD OF THE
                                         GEOGRAPHIC LOCATION OF THE PROVIDER.
                                         (EFF. 10/1/97)
                                    62 = NUMBER OF PART A HOME HEALTH VISITS
                                         ACCRUED DURING A PERIOD OF CONTINUOUS
  1         CLM_VAL_TB                                 CLAIM VALUE TABLE
            ----------                                 -----------------

                                         CARE - NECESSITATED BY THE CHANGE IN
                                         PAYMENT BASIS UNDER HH PPS (EFF. 10/00)
                                    63 = NUMBER OF PART B HOME HEALTH VISITS
                                         ACCRUED DURING A PERIOD OF CONTINUOUS
                                         CARE - NECESSITATED BY THE CHANGE IN
                                         PAYMENT BASIS UNDER HH PPS (EFF. 10/00)
                                    64 = AMOUNT OF HOME HEALTH PAYMENTS ATTRIBUTED
                                         TO THE PART A TRUST FUND IN A PERIOD
                                         OF CONTINUOUS CARE - NECESSITATED BY THE
                                         CHANGE IN PAYMENT BASIS UNDER HH PPS
                                         (EFF. 10/00)
                                    65 = AMOUNT OF HOME HEALTH PAYMENTS ATTRIBUTED
```

                            TO THE PART B TRUST FUND IN A PERIOD
                            OF CONTINUOUS CARE - NECESSITATED BY THE
                            CHANGE IN PAYMENT BASIS UNDER HH PPS
                            (EFF. 10/00)
        66 = RESERVED FOR NATIONAL ASSIGNMENT.
        67 = PERITONEAL DIALYSIS - THE NUMBER OF
             HOURS OF PERITONEAL DIALYSIS PROVIDED
             DURING THE BILLING PERIOD (ONLY THE
             HOURS SPENT IN THE HOME).
             (EFF. 10/97)
        68 = EPO DRUG - NUMBER OF UNITS OF EPO
             ADMINISTERED RELATING TO THE BILLING
             PERIOD.
        69 = RESERVED FOR NATIONAL ASSIGNMENT
        70 = INTEREST AMOUNT - (PROVIDERS DO NOT
             REPORT THIS.) REPORT THE AMOUNT
             APPLIED TO THIS BILL.
        71 = FUNDING OF ESRD NETWORKS - (PROVIDERS
             DO NOT REPORT THIS.) REPORT THE
             AMOUNT THE MEDICARE PAYMENT WAS
             REDUCED TO HELP FUND THE ESRD NETWORKS.
        72 = FLAT RATE SURGERY CHARGE - CODE
             INDICATES THE AMOUNT OF THE CHARGE FOR
             OUTPATIENT SURGERY WHERE THE HOSPITAL
             HAS SUCH A CHARGING STRUCTURE.
        73 = DRUG DEDUCTIBLE - (FOR INTERNAL USE BY
             THIRD PARTY PAYERS ONLY). REPORT THE
             AMOUNT OF THE DRUG DEDUCTIBLE TO BE
             APPLIED TO THE CLAIM.
        74 = DRUG COINSURANCE - (FOR INTERNAL USE
             BY THIRD PARTY PAYERS ONLY). REPORT
             THE AMOUNT OF DRUG COINSURANCE TO BE
             APPLIED TO THE CLAIM.
        75 = GRAMM/RUDMAN/HOLLINGS - (PROVIDERS DO
             NOT REPORT THIS.) REPORT THE AMOUNT OF
             THE SEQUESTRATION APPLIED TO THIS BILL.
        76 = REPORT PROVIDER'S PERCENTAGE OF
             BILLED CHARGES INTERIM RATE DURING
             BILLING PERIOD. APPLIES TO OP
             HOSPITAL, SNF AND HHA CLAIMS
             WHERE INTERIM RATE IS APPLICABLE.
             REPORT TO LEFT OF DOLLAR/CENTS DELIMITER.
             (TP PAYERS INTERNAL USE ONLY)
        77 = PAYER CODE - THIS CODES IS SET

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                                                ASIDE FOR PAYER USE ONLY.  PROVIDERS
                                                DO NOT REPORT THESE CODES.
  1         CLM_VAL_TB                                          CLAIM VALUE TABLE
            ----------                                         -----------------

                                          78 = PAYER CODE - THIS CODES IS SET
                                               ASIDE FOR PAYER USE ONLY.  PROVIDERS
                                               DO NOT REPORT THESE CODES.
                                          79 = PAYER CODE - THIS CODE IS SET
                                               ASIDE FOR PAYER USE ONLY.  PROVIDERS
                                               DO NOT REPORT THESE CODES.
                                          80 - 99 = RESERVED FOR STATE ASSIGNMENT.
                                          A1 = DEDUCTIBLE PAYER A - THE AMOUNT
                                               ASSUMED BY THE PROVIDER TO BE APPLIED
                                               TO THE PATIENT'S DEDUCTIBLE AMOUNT
                                               INVOLVING THE INDICATED PAYER. (EFF 10/93)
                                               - PRIOR VALUE 07
                                          A2 = COINSURANCE PAYER A - THE AMOUNT ASSUMED
                                               BY THE PROVIDER TO BE APPLIED TO THE
                                               PATIENT'S PART B COINSURANCE AMOUNT
                                               INVOLVING THE INDICATED PAYER. (EFF 10/93)
                                          A4 = SELF-ADMINISTERED DRUGS ADMINISTERED IN AN
                                               EMERGENCY SITUATION - ORDINARILY THE ONLY
                                               NONCOVERED SELF-ADMINISTERED DRUG
                                               PAID FOR UNDER MEDICARE IN AN EMERGENCY
                                               SITUATION IS INSULIN ADMINISTERED TO A
                                               PATIENT IN A DIABETIC COMA. (EFF 7/97)
                                          B1 = DEDUCTIBLE PAYER B - THE AMOUNT
                                               ASSUMED BY THE PROVIDER TO BE APPLIED
                                               TO THE PATIENT'S DEDUCTIBLE AMOUNT
                                               INVOLVING THE INDICATED PAYER. (EFF 10/93)
                                               - PRIOR VALUE 07
                                          B2 = COINSURANCE PAYER B - THE AMOUNT ASSUMED
                                               BY THE PROVIDER TO BE APPLIED TO THE
                                               PATIENT'S PART B COINSURANCE AMOUNT
                                               INVOLVING THE INDICATED PAYER. (EFF 10/93)
                                          C1 = DEDUCTIBLE PAYER C - THE AMOUNT
                                               ASSUMED BY THE PROVIDER TO BE APPLIED
                                               TO THE PATIENT'S DEDUCTIBLE AMOUNT
                                               INVOLVING THE INDICATED PAYER. (EFF 10/93)
                                               - PRIOR VALUE 07
                                          C2 = COINSURANCE PAYER C - THE AMOUNT ASSUMED
                                               BY THE PROVIDER TO BE APPLIED TO THE
                                               PATIENT'S PART B COINSURANCE AMOUNT
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                              INVOLVING THE INDICATED PAYER. (EFF 10/93)
                    Y1 = PART A DEMO PAYMENT - PORTION OF THE
                         PAYMENT DESIGNATED AS REIMBURSEMENT FOR
                         PART A SERVICES PER THE ORD CONTRACT.  NO
                         DEDUCTIBLE OR COINSURANCE HAS BEEN
                         APPLIED.  (EFF. 5/97)
                    Y2 = PART B DEMO PAYMENT - PORTION OF THE
                         PAYMENT DESIGNATED AS REIMBURSEMENT FOR
                         PART B SERVICES FOR THE ORD CONTRACT.
                         NO DEDUCTIBLE OR COINSURANCE HAS BEEN
                         APPLIED.  (EFF. 5/97)
                    Y3 = PART B COINSURANCE - AMOUNT OF PART B
                         COINSURANCE APPLIED BY THE INTERMEDIARY
                         TO THIS DEMO CLAIM.   (EFF. 5/97)
                    Y4 = CONVENTIONAL PROVIDER PART A PAYMENT -
                         AMOUNT MEDICARE WOULD HAVE REIMBURSED
                         THE PROVIDER FOR PART A SERVICES IF
                         THERE HAD BEEN NO DEMO.  (EFF. 5/97)

  1  CTGRY_EQTBL_BENE_IDENT_TB        CATEGORY EQUATABLE BENEFICIARY IDENTIFICATION CODE (BIC) TABLE
     --------------------------       -------------------------------------------------------------


                    NCH BIC               SSA CATEGORIES
                    -------               --------------


                    A  = A;J1;J2;J3;J4;M;M1;T;TA
                    B  = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
                         TB(F);TD(F);TE(F);TW(F)
                    B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
                         TD(M);TE(M);TW(M)
                    B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
                         W7;TG(F);TL(F);TR(F);TX(F)
                    B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
                         TL(M);TR(M);TX(M)
                    B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
                         W8;TH(F);TM(F);TS(F);TY(F)
                    BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
                         WC;TJ(F);TN(F);TT(F);TZ(F)
                    BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
                         WJ;TK(F);TP(F);TU(F);TV(F)
                    BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
                         TY(M)
                    BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
```

```
            TZ(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
     TV(M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = EQUATABLE ONLY TO ITSELF (E.G., F3 IS
        EQUATABLE TO F3)
CA-CZ = EQUATABLE ONLY TO ITSELF.  (E.G., CA IS
        ONLY EQUATABLE TO CA)


        ----------------------------------------
                    RRB CATEGORIES


10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
84 = 84;86
85 = 85
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1 DMERC_LINE_SCRN_RSLT_IND_TB                  DMERC LINE SCREEN RESULT INDICATOR TABLE
  ---------------------------                  ----------------------------------------


  A = DENIED FOR LACK OF MEDICAL NECESSITY;
      HIGHEST LEVEL OF REVIEW WAS AUTOMATED
      LEVEL I REVIEW
  B = REDUCED (PARTIALLY DENIED) FOR LACK
      OF MEDICAL NECESSITY; HIGHEST LEVEL
```

```
                              OF REVIEW WAS AUTOMATED LEVEL I REVIEW
                      C = DENIED AS STATUTORILY NONCOVERED;
                          HIGHEST LEVEL OF REVIEW WAS AUTOMATED
                          LEVEL I REVIEW
                      D = RESERVED FOR FUTURE USE
                      E = PAID AFTER AUTOMATED LEVEL I REVIEW
                      F = DENIED FOR LACK OF MEDICAL NECESSITY;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL I REVIEW
                      G = REDUCED (PARTIALLY DENIED) FOR LACK
                          OF MEDICAL NECESSITY; HIGHEST LEVEL
                          OF REVIEW WAS MANUAL LEVEL I REVIEW
                      H = DENIED AS STATUTORILY NONCOVERED;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL I REVIEW
                      I = DENIED FOR CODING/UNBUNDLING REASONS;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL I REVIEW
                      J = PAID AFTER MANUAL LEVEL I REVIEW
                      K = DENIED FOR LACK OF MEDICAL NECESSITY;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL II REVIEW
                      L = REDUCED (PARTIALLY DENIED) FOR LACK
                          OF MEDICAL NECESSITY; HIGHEST LEVEL
                          OF REVIEW WAS MANUAL LEVEL II REVIEW
                      M = DENIED AS STATUTORILY NONCOVERED;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL II REVIEW
                      N = DENIED FOR CODING/UNBUNDLING REASONS;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL II REVIEW
                      O = PAID AFTER MANUAL LEVEL II REVIEW
                      P = DENIED FOR LACK OF MEDICAL NECESSITY;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL III REVIEW
                      Q = REDUCED (PARTIALLY DENIED) FOR LACK
                          OF MEDICAL NECESSITY; HIGHEST LEVEL
                          OF REVIEW WAS MANUAL LEVEL III REVIEW
                      R = DENIED AS STATUTORILY NONCOVERED;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL III REVIEW
                      S = DENIED FOR CODING/UNBUNDLING REASONS;
                          HIGHEST LEVEL OF REVIEW WAS MANUAL
                          LEVEL III REVIEW
```

```
                                  T = PAID AFTER MANUAL LEVEL III REVIEW

1    DMERC_LINE_SUPLR_TYPE_TB                      DMERC LINE SUPPLIER TYPE TABLE
     ------------------------                      ------------------------------


                              0 = CLINICS, GROUPS, ASSOCIATIONS,
                                  PARTNERSHIPS, OR OTHER ENTITIES
                                  FOR WHOM THE CARRIER'S OWN ID NUMBER
                                  HAS BEEN ASSIGNED.
                              1 = PHYSICIANS OR SUPPLIERS BILLING AS
                                  SOLO PRACTITIONERS FOR WHOM SSN'S ARE
                                  SHOWN IN THE PHYSICIAN ID CODE FIELD.
                              2 = PHYSICIANS OR SUPPLIERS BILLING AS
                                  SOLO PRACTITIONERS FOR WHOM THE CARRIER'S
                                  OWN PHYSICIAN ID CODE IS SHOWN.
                              3 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
                                  FOR WHOM EI NUMBERS ARE USED IN CODING THE
                                  ID FIELD.
                              4 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
                                  FOR WHOM THE CARRIER'S OWN CODE HAS BEEN
                                  SHOWN.
                              5 = INSTITUTIONAL PROVIDERS AND
                                  INDEPENDENT LABORATORIES FOR WHOM EI
                                  NUMBERS ARE USED IN CODING THE ID FIELD.
                              6 = INSTITUTIONAL PROVIDERS AND
                                  INDEPENDENT LABORATORIES FOR WHOM THE
                                  CARRIER'S OWN ID NUMBER IS SHOWN.
                              7 = CLINICS, GROUPS, ASSOCIATIONS, OR
                                  PARTNERSHIPS FOR WHOM EI NUMBERS
                                  ARE USED IN CODING THE ID FIELD.
                              8 = OTHER ENTITIES FOR WHOM EI NUMBERS
                                  ARE USED IN CODING THE ID FIELD OR
                                  PROPRIETORSHIP FOR WHOM EI NUMBERS ARE
                                  USED IN CODING THE ID FIELD.

1    DRG_OUTLIER_STAY_TB              DIAGNOSIS RELATED GROUP OUTLIER PATIENT STAY TABLE
     -------------------              --------------------------------------------------


                              0 = NO OUTLIER
                              1 = DAY OUTLIER (CONDITION CODE 60)
                              2 = COST OUTLIER, (CONDITION CODE 61)
```

```
                            *** NON-PPS ONLY ***

                  6 = VALID DIAGNOSIS RELATED GROUPS (DRG)
                      RECEIVED FROM THE INTERMEDIARY
                  7 = HCFA DEVELOPED DRG
                  8 = HCFA DEVELOPED DRG USING PATIENT STATUS
                      CODE
                  9 = NOT GROUPABLE


1       FI_CLM_ACTN_TB                  FISCAL INTERMEDIARY CLAIM ACTION TABLE
        --------------                  --------------------------------------


                  1 = ORIGINAL DEBIT ACTION (INCLUDES NON-
                      ADJUSTMENT RTI CORRECTION ITEMS) - IT
                      WILL ALWAYS BE A 1 IN REGULAR BILLS.
                  2 = CANCEL BY CREDIT ADJUSTMENT - USED
                      ONLY IN CREDIT/DEBIT PAIRS (UNDER HHPPS,
                      UPDATES THE RAP).
                  3 = SECONDARY DEBIT ADJUSTMENT - USED ONLY
                      IN CREDIT/DEBIT PAIRS (UNDER HHPPS, WOULD
                      BE THE FINAL CLAIM OR AN ADJUSTMENT ON
                      A LUPA).
                  4 = CANCEL ONLY ADJUSTMENT (UNDER HHPPS,
                      RAP/FINAL CLAIM/LUPA).
                  5 = FORCE ACTION CODE 3
                  6 = FORCE ACTION CODE 2
                  8 = BENEFITS REFUSED (FOR INPATIENT BILLS,
                      AN 'R' NONPAYMENT CODE MUST ALSO BE
                      PRESENT
                  9 = PAYMENT REQUESTED (USED ON BILLS THAT
                      REPLACE PREVIOUSLY-SUBMITTED BENEFITS-
                      REFUSED BILLS, ACTION CODE 8.  IN SUCH
                      CASES A DEBIT/CREDIT PAIR IS NOT RE-
                      QUIRED.  FOR INPATIENT BILLS, A 'P'
                      SHOULD BE ENTERED IN THE NONPAYMENT
                      CODE.)

1       FI_NUM_TB                       FISCAL INTERMEDIARY NUMBER TABLE
        ---------                       --------------------------------


                  00010 = ALABAMA BC
                  00020 = ARKANSAS BC
```

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00030 = ARIZONA BC
00040 = CALIFORNIA BC (TERM. 12/00)
00050 = NEW MEXICO BC/CO
00060 = CONNECTICUT BC
00070 = DELAWARE BC - TERMINATED 2/98
00080 = FLORIDA BC
00090 = FLORIDA BC
00101 = GEORGIA BC
00121 = ILLINOIS - HCSC
00123 = MICHIGAN - HCSC
00130 = INDIANA BC/ADMINISTAR FEDERAL
00131 = ILLINOIS - ADMINISTAR
00140 = IOWA - WELLMARK (TERM. 6/2000)
00150 = KANSAS BC
00160 = KENTUCKY/ADMINISTAR
00180 = MAINE BC
00181 = MAINE BC - MASSACHUSETTS
00190 = MARYLAND BC
00200 = MASSACHUSETTS BC - TERMINATED 7/97
00210 = MICHIGAN BC - TERMINATED 9/94
00220 = MINNESOTA BC
00230 = MISSISSIPPI BC
00231 = MISSISSIPPI BC/LA
00232 = MISSISSIPPI BC
00241 = MISSOURI BC - TERMINATED 9/92
00250 = MONTANA BC
00260 = NEBRASKA BC
00270 = NEW HAMPSHIRE/VT BC
00280 = NEW JERSEY BC (TERM. 8/2000)
00290 = NEW MEXICO BC - TERMINATED 11/95
00308 = EMPIRE BC
00310 = NORTH CAROLINA BC
00320 = NORTH DAKOTA BC
00332 = COMMUNITY MUTUAL INS CO; OHIO-ADMINISTAR
00340 = OKLAHOMA BC
00350 = OREGON BC
00351 = OREGON BC/ID.
00355 = OREGON-CWF
00362 = INDEPENDENCE BC - TERMINATED 8/97
00363 = VERITUS, INC (PITTS)
00370 = RHODE ISLAND BC
00380 = SOUTH CAROLINA BC
00390 = TENNESSEE BC
00400 = TEXAS BC
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                                    00410 = UTAH BC
                                    00423 = VIRGINIA BC; TRIGON
                                    00430 = WASHINGTON/ALASKA BC
                                    00450 = WISCONSIN BC
                                    00452 = MICHIGAN - WISCONSIN BC
                                    00454 = UNITED GOVERNMENT SERVICES -
                                            WISCONSIN BC (EFF. 12/00)
                                    00460 = WYOMING BC
                                    00468 = N CAROLINA BC/CPRTIVA
                                    00993 = BC/BS ASSOC.
                                    17120 = HAWAII MEDICAL SERVICE
1          FI_NUM_TB                           FISCAL INTERMEDIARY NUMBER TABLE
           ---------                           --------------------------------


                                    50333 = TRAVELERS; CONNECTICUT UNITED HEALTHCARE
                                            (TERMINATED - DATE UNKNOWN)
                                    51051 = AETNA CALIFORNIA - TERMINATED 6/97
                                    51070 = AETNA CONNECTICUT - TERMINATED 6/97
                                    51100 = AETNA FLORIDA - TERMINATED 6/97
                                    51140 = AETNA ILLINOIS - TERMINATED 6/97
                                    51390 = AETNA PENNSYLVANIA - TERMINATED 6/97
                                    52280 = MUTUAL OF OMAHA
                                    57400 = COOPERATIVE, SAN JUAN, PR
                                    61000 = AETNA


1   FI_RQST_CLM_CNCL_RSN_TB                    CLAIM CANCEL REASON CODE TABLE
    -----------------------                    ------------------------------



                                    C = COVERAGE TRANSFER
                                    D = DUPLICATE BILLING
                                    H = OTHER OR BLANK
                                    L = COMBINING TWO BENEFICIARY MASTER RECORDS
                                    P = PLAN TRANSFER
                                    S = SCRAMBLE
                                    ************FOR ACTION CODE 4 ******************
                                    *********EFFECTIVE WITH HHPPS - 10/00***********
                                    A = RAP/FINAL CLAIM/LUPA IS CANCELLED BY INTERME-
                                        DIARY.  DOES NOT DELETE EPISODE.  DO NOT SET
                                        CANCELLATION INDICATOR.
                                    B = RAP/FINAL CLAIM/LUPA IS CANCELLED BY INTERME-
                                        DIARY.  DOES NOT DELETE EPISODE.  SET
                                        CANCELLATION INDICATOR TO 1.
                                    E = RAP/FINAL CLAIM/LUPA IS CANCELLED BY INTERME-
```

```
                              DIARY.  REMOVE EPISODE.
                          F = RAP/FINAL CLAIM/LUPA IS CANCELLED BY PROVIDER.
                              REMOVE EPISODE.

   1        GEO_SSA_STATE_TB                                STATE TABLE
            ----------------                                -----------


                                    01 = ALABAMA
                                    02 = ALASKA
                                    03 = ARIZONA
                                    04 = ARKANSAS
                                    05 = CALIFORNIA
                                    06 = COLORADO
                                    07 = CONNECTICUT
                                    08 = DELAWARE
                                    09 = DISTRICT OF COLUMBIA
                                    10 = FLORIDA
                                    11 = GEORGIA
                                    12 = HAWAII
                                    13 = IDAHO
                                    14 = ILLINOIS
                                    15 = INDIANA
                                    16 = IOWA
                                    17 = KANSAS
                                    18 = KENTUCKY
                                    19 = LOUISIANA
                                    20 = MAINE
                                    21 = MARYLAND
                                    22 = MASSACHUSETTS
                                    23 = MICHIGAN
                                    24 = MINNESOTA
                                    25 = MISSISSIPPI
                                    26 = MISSOURI
                                    27 = MONTANA
                                    28 = NEBRASKA
                                    29 = NEVADA
                                    30 = NEW HAMPSHIRE
                                    31 = NEW JERSEY
                                    32 = NEW MEXICO
                                    33 = NEW YORK
                                    34 = NORTH CAROLINA
                                    35 = NORTH DAKOTA
                                    36 = OHIO
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                                     37 = OKLAHOMA
                                     38 = OREGON
                                     39 = PENNSYLVANIA
                                     40 = PUERTO RICO
                                     41 = RHODE ISLAND
                                     42 = SOUTH CAROLINA
                                     43 = SOUTH DAKOTA
                                     44 = TENNESSEE
                                     45 = TEXAS
                                     46 = UTAH
                                     47 = VERMONT
                                     48 = VIRGIN ISLANDS
                                     49 = VIRGINIA
                                     50 = WASHINGTON
                                     51 = WEST VIRGINIA
                                     52 = WISCONSIN
                                     53 = WYOMING
                                     54 = AFRICA
                                     55 = ASIA
                                     56 = CANADA & ISLANDS
                                     57 = CENTRAL AMERICA AND WEST INDIES
 1      GEO_SSA_STATE_TB                                        STATE TABLE
        ----------------                                        -----------


                                     58 = EUROPE
                                     59 = MEXICO
                                     60 = OCEANIA
                                     61 = PHILIPPINES
                                     62 = SOUTH AMERICA
                                     63 = U.S. POSSESSIONS
                                     64 = AMERICAN SAMOA
                                     65 = GUAM
                                     66 = SAIPAN
                                     97 = NORTHERN MARIANAS
                                     98 = GUAM
                                     99 = WITH 000 COUNTY CODE IS AMERICAN SAMOA;
                                          OTHERWISE UNKNOWN


 1      HCFA_PRVDR_SPCLTY_TB                      HCFA PROVIDER SPECIALTY TABLE
        --------------------                      -----------------------------


                             **PRIOR TO 5/92**
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```
                        01 = GENERAL PRACTICE
                        02 = GENERAL SURGERY
                        03 = ALLERGY (REVISED 10/91 TO MEAN ALLERGY/
                             IMMUNOLOGY)
                        04 = OTOLOGY, LARYNGOLOGY, RHINOLOGY
                             REVISED 10/91 TO MEAN OTOLARYNGOLOGY)
                        05 = ANESTHESIOLOGY
                        06 = CARDIOVASCULAR DISEASE (REVISED 10/91
                             TO MEAN CARDIOLOGY)
                        07 = DERMATOLOGY
                        08 = FAMILY PRACTICE
                        09 = GYNECOLOGY--OSTEOPATHS ONLY (DELETED
                             10/91; CHANGED TO '16')
                        10 = GASTROENTEROLOGY
                        11 = INTERNAL MEDICINE
                        12 = MANIPULATIVE THERAPY (OSTEOPATHS ONLY)
                             (REVISED 10/91 TO MEAN OSTEOPATHIC
                             MANIPULATIVE THERAPY)
                        13 = NEUROLOGY
                        14 = NEUROLOGICAL SURGERY (REVISED 10/91 TO
                             MEAN NEUROSURGERY)
                        15 = OBSTETRICS--OSTEOPATHS ONLY (DELETED
                             10/91; CHANGED TO '16')
                        16 = OB-GYNECOLOGY
                        17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY
                             RHINOLOGY--OSTEOPATHS ONLY (DELETED
                             10/91; CHANGED TO '18' IF PHYSICIANS
                             PRACTICE IS MORE THAN 50% OPHTHALMOLOGY
                             OR TO '04' IF PHYSICIAN'S PRACTICE IS
                             MORE THAN 50% OTOLARYNGOLOGY.  IF
                             PRACTICE IS 50/50, CHOOSE SPECIALTY
                             WITH GREATER ALLOWED CHARGES.
                        18 = OPHTHALMOLOGY
                        19 = ORAL SURGERY (DENTISTS ONLY)
                        20 = ORTHOPEDIC SURGERY
                        21 = PATHOLOGIC ANATOMY, CLINICAL PATHOLOGY-
                             OSTEOPATHS ONLY (DELETED 10/91;
                             CHANGED TO '22')
                        22 = PATHOLOGY
                        23 = PERIPHERAL VASCULAR DISEASE OR SURGERY
                             (DELETED 10/91; CHANGED TO '76')
                        24 = PLASTIC SURGERY (REVISED TO MEAN
                             PLASTIC AND RECONSTRUCTIVE SURGERY).
                        25 = PHYSICAL MEDICINE AND REHABILITATION
```

```
                              26 = PSYCHIATRY
                              27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS ONLY)
                                     (DELETED 10/91; CHANGED TO '86')
                              28 = PROCTOLOGY (REVISED 10/91 TO MEAN
                                     COLORECTAL SURGERY).
                              29 = PULMONARY DISEASE
                              30 = RADIOLOGY (REVISED 10/91 TO MEAN
                                     DIAGNOSTIC RADIOLOGY)
                              31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS)
                                     (DELETED 10/91; CHANGED TO '30')
                              32 = RADIATION THERAPY--OSTEOPATHS (DELETED
1       HCFA_PRVDR_SPCLTY_TB                   HCFA PROVIDER SPECIALTY TABLE
        --------------------                   ----------------------------

                                 10/91; CHANGED TO '92')
                              33 = THORACIC SURGERY
                              34 = UROLOGY
                              35 = CHIROPRACTOR, LICENSED (REVISED 10/91
                                     TO MEAN CHIROPRACTIC)
                              36 = NUCLEAR MEDICINE
                              37 = PEDIATRICS (REVISED 10/91 TO MEAN
                                     PEDIATRIC MEDICINE)
                              38 = GERIATRICS (REVISED 10/91 TO MEAN
                                     GERIATRIC MEDICINE)
                              39 = NEPHROLOGY
                              40 = HAND SURGERY
                              41 = OPTOMETRIST - SERVICES RELATED TO
                                     CONDITION OF APHAKIA (REVISED 10/91 TO
                                     MEAN OPTOMETRIST)
                              42 = CERTIFIED NURSE MIDWIFE (ADDED 7/88)
                              43 = CERTIFIED REGISTERED NURSE ANESTHETIST
                                     (REVISED 10/91 TO MEAN CRNA,
                                     ANESTHESIA ASSISTANT)
                              44 = INFECTIOUS DISEASE
                              46 = ENDOCRINOLOGY (ADDED 10/91)
                              48 = PODIATRY - SURGERY CHIROPODY (REVISED
                                     10/91 TO MEAN PODIATRY)
                              49 = MISCELLANEOUS (INCLUDE ASCS)
                              51 = MEDICAL SUPPLY COMPANY WITH C.O.
                                     CERTIFICATION (CERTIFIED ORTHOTIST -
                                     CERTIFIED BY AMERICAN BOARD FOR
                                     CERTIFICATION IN PROSTHETICS AND
                                     ORTHOTICS.
                              52 = MEDICAL SUPPLY COMPANY WITH C.P.
```

```
                             CERTIFICATION (CERTIFIED PROSTHETIST -
                             CERTIFIED BY AMERICAN BOARD FOR
                             CERTIFICATION IN PROSTHETICS AND ORTHOTICS).
                        53 = MEDICAL SUPPLY COMPANY WITH C.P.O.
                             CERTIFICATION (CERTIFIED PROSTHETIST -
                             ORTHOTIST - CERTIFIED BY AMERICAN
                             BOARD FOR CERTIFICATION IN PROSTHETICS
                             AND ORTHOTICS).
                        54 = MEDICAL SUPPLY COMPANY NOT INCLUDED IN
                             51, 52, OR 53.
                        55 = INDIVIDUAL CERTIFIED ORTHOTIST
                        56 = INDIVIDUAL CERTIFIED PROSTHETIST
                        57 = INDIVIDUAL CERTIFIED PROSTHETIST -
                             ORTHOTIST
                        58 = INDIVIDUALS NOT INCLUDED IN 55,56 OR 57
                        59 = AMBULANCE SERVICE SUPPLIER (E.G.
                             PRIVATE AMBULANCE COMPANIES, FUNERAL
                             HOMES, ETC.)
                        60 = PUBLIC HEALTH OR WELFARE AGENCIES
                             (FEDERAL, STATE, AND LOCAL)
                        61 = VOLUNTARY HEALTH OR CHARITABLE AGENCIES
                             (E.G. NATIONAL CANCER SOCIETY, NATIONAL
                             HEART ASSOCIATION, CATHOLIC CHARITIES)
                        62 = PSYCHOLOGIST--BILLING INDEPENDENTLY
                        63 = PORTABLE X-RAY SUPPLIER--BILLING
                             INDEPENDENTLY (REVISED 10/91 TO MEAN
                             PORTABLE X-RAY SUPPLIER)
                        64 = AUDIOLOGIST (BILLING INDEPENDENTLY)
  1      HCFA_PRVDR_SPCLTY_TB                 HCFA PROVIDER SPECIALTY TABLE
         --------------------                 ---------------------------

                        65 = PHYSICAL THERAPIST (INDEPENDENT PRACTICE)
                        66 = RHEUMATOLOGY (ADDED 10/91)
                        67 = OCCUPATIONAL THERAPIST--INDEPENDENT
                             PRACTICE
                        68 = CLINICAL PSYCHOLOGIST
                        69 = INDEPENDENT LABORATORY--BILLING
                             INDEPENDENTLY (REVISED 10/91 TO MEAN
                             INDEPENDENT CLINICAL LABORATORY --
                             BILLING INDEPENDENTLY)
                        70 = CLINIC OR OTHER GROUP PRACTICE, EXCEPT
                             GROUP PRACTICE PREPAYMENT PLAN (GPPP)
                        71 = GROUP PRACTICE PREPAYMENT PLAN - DIAGNOSTIC
                             X-RAY (DO NOT USE AFTER 1/92)
```

```
72 = GROUP PRACTICE PREPAYMENT PLAN - DIAGNOSTIC
     LABORATORY (DO NOT USE AFTER 1/92)
73 = GROUP PRACTICE PREPAYMENT PLAN -
     PHYSIOTHERAPY (DO NOT USE AFTER 1/92)
74 = GROUP PRACTICE PREPAYMENT PLAN - OCCUPATIONAL
     THERAPY (DO NOT USE AFTER 1/92)
75 = GROUP PRACTICE PREPAYMENT PLAN - OTHER
     MEDICAL CARE (DO NOT USE AFTER 1/92)
76 = PERIPHERAL VASCULAR DISEASE
     (ADDED 10/91)
77 = VASCULAR SURGERY (ADDED 10/91)
78 = CARDIAC SURGERY (ADDED 10/91)
79 = ADDICTION MEDICINE (ADDED 10/91)
8O = CLINICAL SOCIAL WORKER (1991)
81 = CRITICAL CARE-INTENSIVISTS (ADDED 10/91)
82 = OPHTHALMOLOGY, CATARACTS SPECIALTY
     (ADDED 10/91; USED ONLY UNTIL 5/92)
83 = HEMATOLOGY/ONCOLOGY (ADDED 10/91)
84 = PREVENTIVE MEDICINE (ADDED 10/91)
85 = MAXILLOFACIAL SURGERY (ADDED 10/91)
86 = NEUROPSYCHIATRY (ADDED 10/91)
87 = ALL OTHER (E.G. DRUG AND DEPARTMENT
     STORES) (REVISED 10/91 TO MEAN ALL
     OTHER SUPPLIERS)
88 = UNKNOWN (REVISED 10/91 TO MEAN
     PHYSICIAN ASSISTANT)
90 = MEDICAL ONCOLOGY (ADDED 10/91)
91 = SURGICAL ONCOLOGY (ADDED 10/91)
92 = RADIATION ONCOLOGY (ADDED 10/91)
93 = EMERGENCY MEDICINE (ADDED 10/91)
94 = INTERVENTIONAL RADIOLOGY (ADDED 10/91)
95 = INDEPENDENT PHYSIOLOGICAL LABORATORY
     (ADDED 10/91)
96 = UNKNOWN PHYSICIAN SPECIALTY
     (ADDED 10/91)
99 = UNKNOWN--INCL. SOCIAL WORKER'S
     PSYCHIATRIC SERVICES (REVISED 10/91 TO
     MEAN UNKNOWN SUPPLIER/PROVIDER)
     ---------------------------------------
            **EFFECTIVE 5/92**

00 = CARRIER WIDE
01 = GENERAL PRACTICE
02 = GENERAL SURGERY
```

```
                                        03 = ALLERGY/IMMUNOLOGY
1       HCFA_PRVDR_SPCLTY_TB                      HCFA PROVIDER SPECIALTY TABLE
        --------------------                      -----------------------------

                                        04 = OTOLARYNGOLOGY
                                        05 = ANESTHESIOLOGY
                                        06 = CARDIOLOGY
                                        07 = DERMATOLOGY
                                        08 = FAMILY PRACTICE
                                        09 = GYNECOLOGY (OSTEOPATHS ONLY)
                                             (DISCONTINUED 5/92 USE CODE 16)
                                        10 = GASTROENTEROLOGY
                                        11 = INTERNAL MEDICINE
                                        12 = OSTEOPATHIC MANIPULATIVE THERAPY
                                        13 = NEUROLOGY
                                        14 = NEUROSURGERY
                                        15 = OBSTETRICS (OSTEOPATHS ONLY)
                                             (DISCONTINUED 5/92 USE CODE 16)
                                        16 = OBSTETRICS/GYNECOLOGY
                                        17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY,
                                             RHINOLOGY (OSTEOPATHS ONLY)
                                             (DISCONTINUED 5/92 USE CODES 18 OR 04
                                             DEPENDING ON PERCENTAGE OF PRACTICE)
                                        18 = OPHTHALMOLOGY
                                        19 = ORAL SURGERY (DENTISTS ONLY)
                                        20 = ORTHOPEDIC SURGERY
                                        21 = PATHOLOGIC ANATOMY, CLINICAL
                                             PATHOLOGY (OSTEOPATHS ONLY)
                                             (DISCONTINUED 5/92 USE CODE 22)
                                        22 = PATHOLOGY
                                        23 = PERIPHERAL VASCULAR DISEASE, MEDICAL
                                             OR SURGICAL (OSTEOPATHS ONLY)
                                             (DISCONTINUED 5/92 USE CODE 76)
                                        24 = PLASTIC AND RECONSTRUCTIVE SURGERY
                                        25 = PHYSICAL MEDICINE AND REHABILITATION
                                        26 = PSYCHIATRY
                                        27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS
                                             ONLY) (DISCONTINUED 5/92 USE CODE 86)
                                        28 = COLORECTAL SURGERY (FORMERLY
                                             PROCTOLOGY)
                                        29 = PULMONARY DISEASE
                                        30 = DIAGNOSTIC RADIOLOGY
                                        31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS
                                             ONLY) (DISCONTINUED 5/92 USE CODE 30)
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```
                              32 = RADIATION THERAPY (OSTEOPATHS ONLY)
                                   (DISCONTINUED 5/92 USE CODE 92)
                              33 = THORACIC SURGERY
                              34 = UROLOGY
                              35 = CHIROPRACTIC
                              36 = NUCLEAR MEDICINE
                              37 = PEDIATRIC MEDICINE
                              38 = GERIATRIC MEDICINE
                              39 = NEPHROLOGY
                              40 = HAND SURGERY
                              41 = OPTOMETRY (REVISED 10/93 TO
                                   MEAN OPTOMETRIST)
                              42 = CERTIFIED NURSE MIDWIFE (EFF 1/87)
                              43 = CRNA, ANESTHESIA ASSISTANT
                                   (EFF 1/87)
                              44 = INFECTIOUS DISEASE
                              45 = MAMMOGRAPHY SCREENING CENTER
                              46 = ENDOCRINOLOGY (EFF 5/92)
 1      HCFA_PRVDR_SPCLTY_TB                      HCFA PROVIDER SPECIALTY TABLE
        --------------------                      -----------------------------

                              47 = INDEPENDENT DIAGNOSTIC TESTING FACILITY
                                   (IDTF) (EFF. 6/98)
                              48 = PODIATRY
                              49 = AMBULATORY SURGICAL CENTER
                                   (FORMERLY MISCELLANEOUS)
                              50 = NURSE PRACTITIONER
                              51 = MEDICAL SUPPLY COMPANY WITH
                                   CERTIFIED ORTHOTIST (CERTIFIED BY
                                   AMERICAN BOARD FOR CERTIFICATION IN
                                   PROSTHETICS AND ORTHOTICS)
                              52 = MEDICAL SUPPLY COMPANY WITH
                                   CERTIFIED PROSTHETIST
                                   (CERTIFIED BY AMERICAN BOARD FOR
                                   CERTIFICATION IN PROSTHETICS AND
                                   ORTHOTICS)
                              53 = MEDICAL SUPPLY COMPANY WITH
                                   CERTIFIED PROSTHETIST-ORTHOTIST
                                   (CERTIFIED BY AMERICAN BOARD FOR
                                   CERTIFICATION IN PROSTHETICS
                                   AND ORTHOTICS)
                              54 = MEDICAL SUPPLY COMPANY NOT INCLUDED
                                   IN 51, 52, OR 53.  (REVISED 10/93
                                   TO MEAN MEDICAL SUPPLY COMPANY FOR DMERC)
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```
                          55 = INDIVIDUAL CERTIFIED ORTHOTIST
                          56 = INDIVIDUAL CERTIFIED PROSTHETIST
                          57 = INDIVIDUAL CERTIFIED PROSTHETIST-
                               ORTHOTIST
                          58 = INDIVIDUALS NOT INCLUDED IN 55, 56,
                               OR 57 (REVISED 10/93  TO MEAN MEDICAL
                               SUPPLY COMPANY WITH REGISTERED
                               PHARMACIST)
                          59 = AMBULANCE SERVICE SUPPLIER, E.G.,
                               PRIVATE AMBULANCE COMPANIES, FUNERAL
                               HOMES, ETC.
                          60 = PUBLIC HEALTH OR WELFARE AGENCIES
                               (FEDERAL, STATE, AND LOCAL)
                          61 = VOLUNTARY HEALTH OR CHARITABLE
                               AGENCIES (E.G., NATIONAL CANCER
                               SOCIETY, NATIONAL HEART ASSOCIIATION,
                               CATHOLIC CHARITIES)
                          62 = PSYCHOLOGIST (BILLING INDEPENDENTLY)
                          63 = PORTABLE X-RAY SUPPLIER
                          64 = AUDIOLOGIST (BILLING INDEPENDENTLY)
                          65 = PHYSICAL THERAPIST (INDEPENDENTLY
                               PRACTICING)
                          66 = RHEUMATOLOGY (EFF 5/92)
                               NOTE: DURING 93/94 DMERC ALSO USED THIS
                               TO MEAN MEDICAL SUPPLY COMPANY WITH
                               RESPIRATORY THERAPIST
                          67 = OCCUPATIONAL THERAPIST (INDEPENDENTLY
                               PRACTICING)
                          68 = CLINICAL PSYCHOLOGIST
                          69 = CLINICAL LABORATORY (BILLING
                               INDEPENDENTLY)
                          70 = MULTISPECIALTY CLINIC OR GROUP
                               PRACTICE
                          71 = DIAGNOSTIC X-RAY (GPPP) (NOT TO
                               BE ASSIGNED AFTER 5/92)
  1     HCFA_PRVDR_SPCLTY_TB                    HCFA PROVIDER SPECIALTY TABLE
        --------------------                    -----------------------------

                          72 = DIAGNOSTIC LABORATORY (GPPP)
                               (NOT TO BE ASSIGNED AFTER 5/92)
                          73 = PHYSIOTHERAPY (GPPP) (NOT TO BE
                               ASSIGNED AFTER 5/92)
                          74 = OCCUPATIONAL THERAPY (GPPP)
                               (NOT TO BE ASSIGNED AFTER 5/92)
```

```
75 = OTHER MEDICAL CARE (GPPP) (NOT TO
     ASSIGNED AFTER 5/92)
76 = PERIPHERAL VASCULAR DISEASE
     (EFF 5/92)
77 = VASCULAR SURGERY (EFF 5/92)
78 = CARDIAC SURGERY (EFF 5/92)
79 = ADDICTION MEDICINE (EFF 5/92)
80 = LICENSED CLINICAL SOCIAL WORKER
81 = CRITICAL CARE (INTENSIVISTS)
     (EFF 5/92)
82 = HEMATOLOGY (EFF 5/92)
83 = HEMATOLOGY/ONCOLOGY (EFF 5/92)
84 = PREVENTIVE MEDICINE (EFF 5/92)
85 = MAXILLOFACIAL SURGERY (EFF 5/92)
86 = NEUROPSYCHIATRY (EFF 5/92)
87 = ALL OTHER SUPPLIERS (E.G. DRUG AND
     DEPARTMENT STORES) (NOTE: DMERC USED
     87 TO MEAN DEPARTMENT STORE FROM 10/93
     THROUGH 9/94; RECODED EFF 10/94 TO A7;
     NCH CROSS-WALKED DMERC REPORTED 87 TO A7.
88 = UNKNOWN SUPPLIER/PROVIDER SPECIALTY
     (NOTE: DMERC USED 87 TO MEAN GROCERY
     STORE FROM 10/93 - 9/94; RECODED EFF
     10/94 TO A8; NCH CROSS-WALKED DMERC
     REPORTED 88 TO A8.
89 = CERTIFIED CLINICAL NURSE SPECIALIST
90 = MEDICAL ONCOLOGY (EFF 5/92)
91 = SURGICAL ONCOLOGY (EFF 5/92)
92 = RADIATION ONCOLOGY (EFF 5/92)
93 = EMERGENCY MEDICINE (EFF 5/92)
94 = INTERVENTIONAL RADIOLOGY (EFF 5/92)
95 = INDEPENDENT PHYSIOLOGICAL
     LABORATORY (EFF 5/92)
96 = OPTICIAN (EFF 10/93)
97 = PHYSICIAN ASSISTANT (EFF 5/92)
98 = GYNECOLOGIST/ONCOLOGIST (EFF 10/94)
99 = UNKNOWN PHYSICIAN SPECIALTY
A0 = HOSPITAL (EFF 10/93) (DMERCS ONLY)
A1 = SNF (EFF 10/93) (DMERCS ONLY)
A2 = INTERMEDIATE CARE NURSING FACILITY
     (EFF 10/93) (DMERCS ONLY)
A3 = NURSING FACILITY, OTHER (EFF 10/93)
     (DMERCS ONLY)
A4 = HHA (EFF 10/93) (DMERCS ONLY)
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                              A5 = PHARMACY (EFF 10/93) (DMERCS ONLY)
                              A6 = MEDICAL SUPPLY COMPANY WITH RESPIRATORY
                                   THERAPIST (EFF 10/93) (DMERCS ONLY)
                              A7 = DEPARTMENT STORE (FOR DMERC USE:
                                   EFF 10/94, BUT CROSS-WALKED FROM
                                   CODE 87 EFF 10/93)
                              A8 = GROCERY STORE (FOR DMERC USE:
                                   EFF 10/94, BUT CROSS-WALKED FROM
1      HCFA_PRVDR_SPCLTY_TB                    HCFA PROVIDER SPECIALTY TABLE
       --------------------                    -----------------------------


                                 CODE 88 EFF 10/93)


1      HCFA_TYPE_SRVC_TB                       HCFA TYPE OF SERVICE TABLE
       -----------------                       --------------------------



                              1 = MEDICAL CARE
                              2 = SURGERY
                              3 = CONSULTATION
                              4 = DIAGNOSTIC RADIOLOGY
                              5 = DIAGNOSTIC LABORATORY
                              6 = THERAPEUTIC RADIOLOGY
                              7 = ANESTHESIA
                              8 = ASSISTANT AT SURGERY
                              9 = OTHER MEDICAL ITEMS OR SERVICES
                              0 = WHOLE BLOOD ONLY EFF 01/96,
                                   WHOLE BLOOD OR PACKED RED CELLS BEFORE 01/96
                              A = USED DURABLE MEDICAL EQUIPMENT (DME)
                              B = HIGH RISK SCREENING MAMMOGRAPHY
                                   (OBSOLETE 1/1/98)
                              C = LOW RISK SCREENING MAMMOGRAPHY
                                   (OBSOLETE 1/1/98)
                              D = AMBULANCE (EFF 04/95)
                              E = ENTERAL/PARENTERAL NUTRIENTS/SUPPLIES
                                   (EFF 04/95)
                              F = AMBULATORY SURGICAL CENTER (FACILITY
                                   USAGE FOR SURGICAL SERVICES)
                              G = IMMUNOSUPPRESSIVE DRUGS
                              H = HOSPICE SERVICES (DISCONTINUED 01/95)
                              I = PURCHASE OF DME (INSTALLMENT BASIS)
                                   (DISCONTINUED 04/95)
                              J = DIABETIC SHOES (EFF 04/95)
                              K = HEARING ITEMS AND SERVICES (EFF 04/95)
```

```
                              L = ESRD SUPPLIES (EFF 04/95)
                                  (RENAL SUPPLIER IN THE HOME BEFORE 04/95)
                              M = MONTHLY CAPITATION PAYMENT FOR DIALYSIS
                              N = KIDNEY DONOR
                              P = LUMP SUM PURCHASE OF DME, PROSTHETICS,
                                  ORTHOTICS
                              Q = VISION ITEMS OR SERVICES
                              R = RENTAL OF DME
                              S = SURGICAL DRESSINGS OR OTHER MEDICAL SUPPLIES
                                  (EFF 04/95)
                              T = PSYCHOLOGICAL THERAPY (TERM. 12/31/97)
                                  OUTPATIENT MENTAL HEALTH LIMITATION (EFF. 1/1/98)
                              U = OCCUPATIONAL THERAPY
                              V = PNEUMOCOCCAL/FLU VACCINE (EFF 01/96),
                                  PNEUMOCOCCAL/FLU/HEPATITIS B VACCINE (EFF 04/95-12/95),
                                  PNEUMOCOCCAL ONLY BEFORE 04/95
                              W = PHYSICAL THERAPY
                              Y = SECOND OPINION ON ELECTIVE SURGERY
                                  (OBSOLETED 1/97)
                              Z = THIRD OPINION ON ELECTIVE SURGERY
                                  (OBSOLETED 1/97)

 1 LINE_ADDTNL_CLM_DCMTN_IND_TB           LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR TABLE
   ---------------------------            ---------------------------------------------------


                              0 = NO ADDITIONAL DOCUMENTATION
                              1 = ADDITIONAL DOCUMENTATION SUBMITTED FOR
                                  NON-DME EMC CLAIM
                              2 = CMN/PRESCRIPTION/OTHER DOCUMENTATION SUBMITTED
                                  WHICH JUSTIFIES MEDICAL NECESSITY
                              3 = PRIOR AUTHORIZATION OBTAINED AND APPROVED
                              4 = PRIOR AUTHORIZATION REQUESTED BUT NOT APPROVED
                              5 = CMN/PRESCRIPTION/OTHER DOCUMENTATION SUBMITTED
                                  BUT DID NOT JUSTIFY MEDICAL NECESSITY
                              6 = CMN/PRESCRIPTION/OTHER DOCUMENTATION SUBMITTED
                                  AND APPROVED AFTER PRIOR AUTHORIZATION REJECTED
                              7 = RECERTIFICATION CMN/PRESCRIPTION/OTHER
                                  DOCUMENTATION

 1      LINE_PLC_SRVC_TB                            LINE PLACE OF SERVICE TABLE
        ----------------                            ---------------------------
```

```
                        **PRIOR TO 1/92**

            1 = OFFICE
            2 = HOME
            3 = INPATIENT HOSPITAL
            4 = SNF
            5 = OUTPATIENT HOSPITAL
            6 = INDEPENDENT LAB
            7 = OTHER
            8 = INDEPENDENT KIDNEY DISEASE TREATMENT
                CENTER
            9 = AMBULATORY
            A = AMBULANCE SERVICE
            H = HOSPICE
            M = MENTAL HEALTH, RURAL MENTAL HEALTH
            N = NURSING HOME
            R = RURAL CODES


                ---------------------------------------
                        **EFFECTIVE 1/92**

           11 = OFFICE
           12 = HOME
           21 = INPATIENT HOSPITAL
           22 = OUTPATIENT HOSPITAL
           23 = EMERGENCY ROOM - HOSPITAL
           24 = AMBULATORY SURGICAL CENTER
           25 = BIRTHING CENTER
           26 = MILITARY TREATMENT FACILITY
           31 = SKILLED NURSING FACILITY
           32 = NURSING FACILITY
           33 = CUSTODIAL CARE FACILITY
           34 = HOSPICE
           35 = ADULT LIVING CARE FACILITIES (ALCF)
                (EFF. NYD - ADDED 12/3/97)
           41 = AMBULANCE - LAND
           42 = AMBULANCE - AIR OR WATER
           50 = FEDERALLY QUALIFIED HEALTH CENTERS
                (EFF. 10/1/93)
           51 = INPATIENT PSYCHIATRIC FACILITY
           52 = PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
           53 = COMMUNITY MENTAL HEALTH CENTER
           54 = INTERMEDIATE CARE FACILITY/MENTALLY
                RETARDED
```

```
                          55 = RESIDENTIAL SUBSTANCE ABUSE TREATMENT
                               FACILITY
                          56 = PSYCHIATRIC RESIDENTIAL TREATMENT
                               CENTER
                          60 = MASS IMMUNIZATIONS CENTER (EFF. 9/1/97)
                          61 = COMPREHENSIVE INPATIENT REHABILITATION
                               FACILITY
                          62 = COMPREHENSIVE OUTPATIENT REHABILITATION
                               FACILITY
                          65 = END STAGE RENAL DISEASE TREATMENT FACILITY
                          71 = STATE OR LOCAL PUBLIC HEALTH CLINIC
                          72 = RURAL HEALTH CLINIC
                          81 = INDEPENDENT LABORATORY
1       LINE_PLC_SRVC_TB                        LINE PLACE OF SERVICE TABLE
        ----------------                        ---------------------------

                          99 = OTHER UNLISTED FACILITY


1       LINE_PMT_IND_TB                         LINE PAYMENT INDICATOR TABLE
        ---------------                         ----------------------------


                          1 = ACTUAL CHARGE
                          2 = CUSTOMARY CHARGE
                          3 = PREVAILING CHARGE (ADJUSTED, UNADJUSTED
                              GAP FILL, ETC)
                          4 = OTHER (ASC FEES, RADIOLOGY AND
                              OUTPATIENT LIMITS, AND NON-PAYMENT
                              BECAUSE OF DENIAL.
                          5 = LAB FEE SCHEDULE
                          6 = PHYSICIAN FEE SCHEDULE - FULL FEE
                              SCHEDULE AMOUNT
                          7 = PHYSICIAN FEE SCHEDULE - TRANSITION
                          8 = CLINICAL PSYCHOLOGIST FEE SCHEDULE
                          9 = DME AND PROSTHETICS/ORTHOTICS FEE
                              SCHEDULES (EFF. 4/97)


1       LINE_PRCSG_IND_TB                       LINE PROCESSING INDICATOR TABLE
        -----------------                       -------------------------------


                          A = ALLOWED
                          B = BENEFITS EXHAUSTED
                          C = NONCOVERED CARE
```

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                                   D = DENIED (EXISTED PRIOR TO 1991; FROM
                                       BMAD)
                                   I = INVALID DATA
                                   L = CLIA (EFF 9/92)
                                   M = MULTIPLE SUBMITTAL--DUPLICATE LINE ITEM
                                   N = MEDICALLY UNNECESSARY
                                   O = OTHER
                                   P = PHYSICIAN OWNERSHIP DENIAL (EFF 3/92)
                                   Q = MSP COST AVOIDED (CONTRACTOR #88888) -
                                       VOLUNTARY AGREEMENT (EFF. 1/98)
                                   R = REPROCESSED--ADJUSTMENTS BASED ON
                                       SUBSEQUENT REPROCESSING OF CLAIM
                                   S = SECONDARY PAYER
                                   T = MSP COST AVOIDED - IEQ CONTRACTOR
                                       (EFF. 7/76)
                                   U = MSP COST AVOIDED - HMO RATE CELL
                                       ADJUSTMENT (EFF. 7/96)
                                   V = MSP COST AVOIDED - LITIGATION
                                       SETTLEMENT (EFF. 7/96)
                                   X = MSP COST AVOIDED - GENERIC
                                   Y = MSP COST AVOIDED - IRS/SSA DATA
                                       MATCH PROJECT
                                   Z = BUNDLED TEST, NO PAYMENT
                                       (EFF. 1/1/98)

   1   LINE_PRVDR_PRTCPTG_IND_TB               LINE PROVIDER PARTICIPATING INDICATOR TABLE
       -------------------------               ------------------------------------------


                                   1 = PARTICIPATING
                                   2 = ALL OR SOME COVERED AND ALLOWED
                                       EXPENSES APPLIED TO DEDUCTIBLE PARTICIPATING
                                   3 = ASSIGNMENT ACCEPTED/NON-PARTICIPATING
                                   4 = ASSIGNMENT NOT ACCEPTED/NON-PARTICIPATING
                                   5 = ASSIGNMENT ACCEPTED BUT ALL OR SOME
                                       COVERED AND ALLOWED EXPENSES APPLIED
                                       TO DEDUCTIBLE NON-PARTICIPATING.
                                   6 = ASSIGNMENT NOT ACCEPTED AND ALL COVERED
                                       AND ALLOWED EXPENSES APPLIED TO DEDUCTIBLE
                                       NON-PARTICIPATING.
                                   7 = PARTICIPATING PROVIDER NOT ACCEPTING
                                       ASSIGNMENT.

   1      NCH_CLM_TYPE_TB                               NCH CLAIM TYPE TABLE
```

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                                10 = HHA CLAIM
                                20 = NON SWING BED SNF CLAIM
                                30 = SWING BED SNF CLAIM
                                40 = OUTPATIENT CLAIM
                                41 = OUTPATIENT 'FULL-ENCOUNTER' CLAIM
                                     (AVAILABLE IN NMUD)
                                42 = OUTPATIENT 'ABBREVIATED-ENCOUNTER' CLAIM
                                     (AVAILABLE IN NMUD)
                                50 = HOSPICE CLAIM
                                60 = INPATIENT CLAIM
                                61 = INPATIENT 'FULL-ENCOUNTER' CLAIM
                                62 = INPATIENT 'ABBREVIATED-ENCOUNTER CLAIM
                                     (AVAILABLE IN NMUD)
                                71 = RIC O LOCAL CARRIER NON-DMEPOS CLAIM
                                72 = RIC O LOCAL CARRIER DMEPOS CLAIM
                                73 = PHYSICIAN 'FULL-ENCOUNTER' CLAIM
                                     (AVAILABLE IN NMUD)
                                81 = RIC M DMERC NON-DMEPOS CLAIM
                                82 = RIC M DMERC DMEPOS CLAIM

 1         NCH_EDIT_TB                                  NCH EDIT TABLE
           -----------                                  --------------


                                A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
                                A000 = (C) REIMB > $100,000 OR UNITS > 150
                                A002 = (C) CLAIM IDENTIFIER (CAN)
                                A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
                                A004 = (C) PATIENT SURNAME BLANK
                                A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                                A006 = (C) DATE OF BIRTH IS NOT NUMERIC
                                A007 = (C) INVALID GENDER (0, 1, 2)
                                A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
                                A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
                                A1X1 = (C) PERCENT ALLOWED INDICATOR
                                A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
                                A1X3 = (C) DT>96365,DIAG=V725
                                A1X4 = (C) INVALID DIAGNOSTIC CODES
                                C050 = (U) HOSPICE - SPELL VALUE INVALID
                                D102 = (C) DME DATE OF BIRTH INVALID
                                D2X2 = (C) DME SCREEN SAVINGS INVALID
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                               D2X3 = (C) DME SCREEN RESULT INVALID
                               D2X4 = (C) DME DECISION IND INVALID
                               D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
                               D3X1 = (C) DME NATIONAL DRUG CODE INVALID
                               D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
                               D4X2 = (C) DME OUT OF DMERC SERVICE AREA
                               D4X3 = (C) DME STATE CODE INVALID
                               D5X1 = (C) TOS INVALID FOR DME HCPCS
                               D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
                               D5X3 = (C) DME INVALID USE OF MS MODIFIER
                               D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
                               D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
                               D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
                               D6X1 = (C) DME SUPPLIER NUMBER MISSING
                               D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
                               D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
                               D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
                               XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
                               Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
                               Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
                               Y003 = (C) HCPCS R0075/UNITS=SERVICES
                               Y010 = (C) TOB=13X/14X AND T.C.>$7,500
                               Y011 = (C) INP CLAIM/REIM > $75,000
                               Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
                               Z002 = (C) CC M2 PRESENT/REIMB > $150,000
                               Z003 = (C) CC M2 PRESENT/UNITS > 150
                               Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
                               Z005 = (C) REIMB>99999 AND REIMB<150000
                               Z006 = (C) UNITS>99 AND UNITS<150
                               Z237 = (E) HOSPICE OVERLAP - DATE ZERO
                               0011 = (C) ACTION CODE INVALID
                               0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
                               0014 = (C) DEMO NUM NOT=01-06,08,15,31
                               0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
                               0016 = (C) INVALID VA CLAIM
                               0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
                               0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
                               0020 = (C) CANCEL ONLY CODE INVALID
                               0021 = (C) DEMO COUNT > 1
                               0301 = (C) INVALID HI CLAIM NUMBER
   1        NCH_EDIT_TB                              NCH EDIT TABLE
            -----------                              --------------

                               0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
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                    04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
                    04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                    0401 = (C) BILL TYPE/PROVIDER INVALID
                    0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
                    0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
                    0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
                    0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
                    0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
                    0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
                    0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
                    0414 = (C) VALU CD 61,MSA AMOUNT MISSING
                    0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
                    05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
                    05X5 = (C) UPIN REQUIRED FOR DME HCPCS
                    0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
                    0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
                    0601 = (C) GENDER INVALID
                    0701 = (C) CONTRACTOR INVALID CARRIER/ETC
                    0702 = (C) PROVIDER NUMBER INCONSISTANT
                    0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
                    0704 = (C) INVALID CONT FOR CABG DEMO
                    0705 = (C) INVALID CONT FOR PCOE DEMO
                    0901 = (C) INVALID DISP CODE OF 02
                    0902 = (C) INVALID DISP CODE OF SPACES
                    0903 = (C) INVALID DISP CODE
                    1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
                    13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
                    1301 = (C) LINE COUNT NOT NUMERIC OR > 13
                    1302 = (C) RECORD LENGTH INVALID
                    1401 = (C) INVALID MEDICARE STATUS CODE
                    1501 = (C) ADMIT DATE/ENTRY CODE INVALID
                    1502 = (C) ADMIT DATE > STAY FROM DATE
                    1503 = (C) ADMIT DATE INVALID WITH THRU DATE
                    1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
                    1505 = (C) HCPCS W SERVICE DATES > 09-30-94
                    1601 = (C) INVESTIGATION IND INVALID
                    1701 = (C) SPLIT IND INVALID
                    1801 = (C) PAY-DENY CODE INVALID
                    1802 = (C) HEADER AMT AND NOT DENIED CLAIM
                    1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
                    1901 = (C) AB CROSSOVER IND INVALID
                    2001 = (C) HOSPICE OVERRIDE INVALID
                    2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
                    2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
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                              2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
                              2202 = (C) STAY-FROM DATE > THRU-DATE
                              2203 = (C) THRU DATE INVALID
                              2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
                              2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
                              2207 = (C) MAMMOGRAPHY BEFORE 1991
                              2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
                              2302 = (C) COVERED DAYS INVALID OR INCONSIST
                              2303 = (C) COST REPORT DAYS > ACCOMIDATION
                              2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
                              2305 = (C) UTIL DAYS = INCONSISTENCIES
                              2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
                              2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
  1          NCH_EDIT_TB                              NCH EDIT TABLE
             -----------                              --------------

                              2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
                              2401 = (C) NON-UTIL DAYS INVALID
                              2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
                              2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
                              2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
                              2504 = (C) COINSURANCE AMOUNT EXCESSIVE
                              2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
                              2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
                              2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
                              2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
                              2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
                              2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
                              2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
                              2604 = (C) PPS BILL, NO DAY OUTLIER
                              2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
                              28XA = (C) UTIL DAYS > FROM TO BENEF EXH
                              28XB = (C) BENEFITS EXH DATE > FROM DATE
                              28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
                              28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
                              28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
                              28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
                              28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
                              28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
                              28XN = (C) INVALID OCC CODE
                              28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
                              28X1 = (C) OCCUR DATE INVALID
                              28X2 = (C) OCCUR = 20 AND TRANS = 4
                              28X3 = (C) OCCUR 20 DATE < ADMIT DATE
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                          28X4 = (C) OCCUR 20 DATE > ADMIT + 12
                          28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
                          28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
                          28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
                          28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
                          28X9 = (C) UTIL > FROM - THRU LESS NCOV
                          33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
                          33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
                          33X3 = (C) QS DAYS/ADMISSION ARE INVALID
                          33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
                          33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
                          33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
                          33X7 = (C) TOB<>18/21/28/51,COND=WO
                          33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
                          33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
                          34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
                          3401 = (C) DEMO ID = 04 AND RIC NOT = 1
                          35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
                          35X2 = (C) COND = 60 OR 61 AND NO VALU 17
                          35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
                          36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
                          3701 = (C) ASSIGN CODE INVALID
                          3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
                          3706 = (C) INVALID IDE NUMBER-NOT IN FILE
                          3710 = (C) NUM OF IDE# > REV 0624
                          3715 = (C) NUM OF IDE# < REV 0624
                          3720 = (C) IDE AND LINE ITEM NUMBER > 2
                          3801 = (C) AMT BENE PD INVALID
                          4001 = (C) BLOOD PINTS FURNISHED INVALID
                          4002 = (C) BLOOD FURNISHED/REPLACED INVALID
   1        NCH_EDIT_TB                               NCH EDIT TABLE
            -----------                               --------------

                          4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
                          4201 = (C) BLOOD PINTS UNREPLACED INVALID
                          4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
                          4203 = (C) INVALID CPO PROVIDER NUMBER
                          4301 = (C) BLOOD DEDUCTABLE INVALID
                          4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
                          4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
                          4304 = (C) BLOOD DEDUCT > 3 - REPLACED
                          4501 = (C) PRIMARY DIAGNOSIS INVALID
                          46XA = (C) MSP VET AND VET AT MEDICARE
                          46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
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46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
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                                     51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
                                     51X0 = (C) REV CENTER CODE INVALID
                                     51X1 = (C) REV CODE CHECK
1          NCH_EDIT_TB                                        NCH EDIT TABLE
           -----------                                       --------------

                                     51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
                                     51X3 = (C) UNITS MUST BE > 0
                                     51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
                                     51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
                                     51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
                                     51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
                                     51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
                                     51X9 = (C) HCPCS/REV CODE/BILL TYPE
                                     5100 = (U) TRANSITION SPELL / SNF
                                     5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
                                     5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
                                     5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
                                     5169 = (U) PROVIDER NE TO WORK PROVIDER
                                     5177 = (U) PROVIDER NE TO WORK PROVIDER
                                     5178 = (U) HOSPICE BILL THRU < DOLBA
                                     5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
                                     5200 = (E) ENTITLEMENT EFFECTIVE DATE
                                     5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
                                     5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
                                     5202 = (U) HOSPICE TRAILER ERROR
                                     5203 = (E) ENTITLEMENT HOSPICE PERIODS
                                     5203 = (U) HOSPICE START DATE ERROR
                                     5204 = (U) HOSPICE DATE DIFFERENCE NE 90
                                     5205 = (U) HOSPICE DATE DISCREPANCY
                                     5206 = (U) HOSPICE DATE DISCREPANCY
                                     5207 = (U) HOSPICE THRU > TERM DATE 2ND
                                     5208 = (U) HOSPICE PERIOD NUMBER BLANK
                                     5209 = (U) HOSPICE DATE DISCREPANCY
                                     5210 = (E) ENTITLEMENT FRM/TRU/END DATES
                                     5211 = (E) ENTITLEMENT DATE DEATH/THRU
                                     5212 = (E) ENTITLEMENT DATE DEATH/THRU
                                     5213 = (E) ENTITLEMENT DATE DEATH MBR
                                     5220 = (E) ENTITLEMENT FROM/EFF DATES
                                     5225 = (E) ENT INP PPS SPAN 70 DATES
                                     5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
                                     5233 = (E) ENTITLEMENT HMO PERIODS
                                     5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
                                     5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
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                                  5236 = (E) ENTITLEMENT HMO HOSP + CC07
                                  5237 = (E) ENTITLEMENT HOSP OVERLAP
                                  5238 = (U) HOSPICE CLAIM OVERLAP > 90
                                  5239 = (U) HOSPICE CLAIM OVERLAP > 60
                                  524Z = (E) HOSP OVERLAP NO OVD NO DEMO
                                  5240 = (U) HOSPICE DAYS STAY+USED > 90
                                  5241 = (U) HOSPICE DAYS STAY+USED > 60
                                  5242 = (C) INVALID CARRIER FOR RRB
                                  5243 = (C) HMO=90091,INVALID SERVICE DTE
                                  5244 = (E) DEMO CABG/PCOE MISSING ENTL
                                  5245 = (C) INVALID CARRIER FOR NON RRB
                                  525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
                                  5250 = (U) HOSPICE DOEBA/DOLBA
                                  5255 = (U) HOSPICE DAYS USED
                                  5256 = (U) HOSPICE DAYS USED > 999
                                  526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
                                  526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
                                  527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
                                  527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
                                  5299 = (U) HOSPICE PERIOD NUMBER ERROR
1          NCH_EDIT_TB                                     NCH EDIT TABLE
           -----------                                     --------------

                                  5320 = (U) BILL > DOEBA AND IND-1 = 2
                                  5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
                                  5355 = (U) HOSPICE DAYS USED SECONDARY
                                  5378 = (C) SERVICE DATE < AGE 50
                                  5399 = (U) HOSPICE PERIOD NUM MATCH
                                  5410 = (U) INPAT DEDUCTABLE
                                  5425 = (U) PART B DEDUCTABLE CHECK
                                  5430 = (U) PART B DEDUCTABLE CHECK
                                  5450 = (U) PART B COMPARE MED EXPENSE
                                  5460 = (U) PART B COMPARE MED EXPENSE
                                  5499 = (U) MED EXPENSE TRAILER MISSING
                                  5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
                                  5510 = (U) COIN DAYS/SNF COIN DAYS
                                  5515 = (U) FULL DAYS/COIN DAYS
                                  5516 = (U) SNF FULL DAYS/SNF COIN DAYS
                                  5520 = (U) LIFE RESERVE DAYS
                                  5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
                                  5540 = (U) HH VISITS NE AFT PT B TRLR
                                  5550 = (E) SNF LESS THAN PT A EFF DATE
                                  5600 = (D) LOGICAL DUPE, COVERED
                                  5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
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                              5602 = (D) LOGICAL DUPE, PANDE C, E OR I
                              5603 = (D) LOGICAL DUPE, COVERED
                              5605 = (D) POSS DUPE, OUTPAT REIMB
                              5606 = (D) POSS DUPE, HOME HEALTH COVERED U
                              5623 = (U) NON-PAY CODE IS P
                              57X1 = (C) PROVIDER SPECIALITY CODE INVALID
                              57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
                              57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
                              57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
                              5700 = (U) LINKED TO THREE SPELLS
                              5701 = (C) DEMO ID=02,RIC NOT = 5
                              5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
                              58X1 = (C) PROVIDER TYPE INVALID
                              58X9 = (C) TYPE OF SERVICE INVALID
                              5802 = (C) REIMB > $150,000
                              5803 = (C) UNITS/VISITS > 150
                              5804 = (C) UNITS/VISITS > 99
                              59XA = (C) PROST ORTH HCPCS/FROM DATE
                              59XB = (C) HCPCS/FROM DATE/TYPE P OR I
                              59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
                              59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
                              59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
                              59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
                              59XH = (C) HCPCS E0620/TYPE/DATE
                              59XI = (C) HCPCS E0627-9/ DATE < 1991
                              59XL = (C) HCPCS 00104 - TOS/POS
                              59X1 = (C) INVALID HCPCS/TOS COMBINATION
                              59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
                              59X3 = (C) TOS INVALID TO MODIFIER
                              59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
                              59X5 = (C) MAMMOGRAPHY FOR MALE
                              59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
                              59X7 = (C) CAPPED-HCPCS/FROM DATE
                              59X8 = (C) FREQUENTLY MAINTAINED HCPCS
                              59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
                              5901 = (U) ERROR CODE OF Q
                              60X1 = (C) ASSIGN IND INVALID
1        NCH_EDIT_TB                                  NCH EDIT TABLE
         -----------                                  --------------

                              6000 = (U) ADJUSTMENT BILL SPELL DATA
                              6020 = (U) CURRENT SPELL DOEBA < 1990
                              6030 = (U) ADJUSTMENT BILL SPELL DATA
                              6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
```

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61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
```

```
                              6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
                              6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
                              68X1 = (C) INVALID HCPCS CODE
                              68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
                              68X3 = (C) TYPE OF SERVICE = G /PROC CODE
                              68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
                              68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
                              68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
                              68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
                              68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.
1          NCH_EDIT_TB                               NCH EDIT TABLE
           -----------                               --------------

                              69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
                              69X3 = (C) PROC CODE MOD = LL / TYPE = R
                              69X6 = (C) PROC CODE MOD/NOT CAPPED
                              69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
                              6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
                              6902 = (C) KRON IND AND NO-PAY CODE B OR N
                              6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
                              6904 = (C) KRON IND AND TRANS CODE IS 4
                              6910 = (C) REV CODES ON HOME HEALTH
                              6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
                              6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
                              6913 = (C) REV CODE INVAL FOR OXYGEN
                              6914 = (C) REV CODE INVAL FOR DME
                              6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
                              6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
                              6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
                              6918 = (C) HCPCS INVALID ON DATE RANGES
                              6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
                              6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
                              6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
                              6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
                              6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
                              6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
                              6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
                              6929 = (U) ADJUSTMENT BILL LIFE RESERVE
                              6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
                              7000 = (U) INVALID DOEBA/DOLBA
                              7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
                              7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
                              71X1 = (C) SUBMITTED CHARGES INVALID
                              71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
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                           72X1 = (C) ALLOWED CHGS INVALID
                           72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
                           72X3 = (C) DENIED LINE/ALLOWED CHARGES
                           73X1 = (C) SS NUMBER INVALID
                           73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
                           74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
                           76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
                           77X1 = (C) PLACE OF SERVICE INVALID
                           77X2 = (C) PHYS THERAPY/PLACE
                           77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
                           77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
                           77X6 = (C) TOS=F, PL OF SER NOT = 24
                           7701 = (C) INCORRECT MODIFIER
                           7777 = (D) POSS DUPE, PART B DOC-ID
                           78XA = (C) MAMMOGRAPHY BEFORE 1991
                           78X1 = (C) THRU DATE INVALID
                           78X3 = (C) FROM DATE GREATER THAN THRU DATE
                           78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
                           78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
                           78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
                           79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
                           79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
                           8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
                           8028 = (E) NO ENTITLEMENT
                           8029 = (U) HH BEFORE PERIOD NOT PRESENT
                           8030 = (U) HH BILL VISITS > PT A REMAINING
                           8031 = (U) HH PT A REMAINING > 0
   1         NCH_EDIT_TB                            NCH EDIT TABLE
             -----------                            --------------

                           8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
                           8050 = (U) HH QUALIFYING INDICATOR = 1
                           8051 = (U) HH # VISITS NE AFT PT B APPLIED
                           8052 = (U) HH # VISITS NE AFT TRAILER
                           8053 = (U) HH BENEFIT PERIOD NOT PRESENT
                           8054 = (U) HH DOEBA/DOLBA NOT > 0
                           8060 = (U) HH QUALIFYING INDICATOR NE 1
                           8061 = (U) HH DATE NE DOLBA IN AFT TRLR
                           8062 = (U) HH NE PT-A VISITS REMAINING
                           81X1 = (C) NUM OF SERVICES INVALID
                           83X1 = (C) DIAGNOSIS INVALID
                           8301 = (C) HCPCS/GENDER DIAGNOSIS
                           8302 = (C) HCPCS G0101 V-CODE/SEX CODE
                           8304 = (C) BILL TYPE INVALID FOR G0123/4
```

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84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
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1          NCH_EDIT_TB                                          NCH EDIT TABLE
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                                        94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
                                        94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
                                        94G4 = (C) NO PAY CODE = R & REIMB PRESENT
                                        94X1 = (C) BLOOD LIMIT INVALID
                                        94X2 = (C) TYPE/BLOOD DEDUCTIBLE
                                        94X3 = (C) TYPE/DATE/LIMIT AMOUNT
                                        94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
                                        94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
                                        9401 = (C) BLOOD DEDUCTIBLE AMT > 3
                                        9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
                                        9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
                                        9404 = (C) INVALID GENDER CODE ON PRO-PAY
                                        9407 = (C) INVALID DRG NUMBER
                                        9408 = (C) INVALID DRG NUMBER (GLOBAL)
                                        9409 = (C) HCFA DRG<>DRG ON BILL
                                        9410 = (C) CABG/PCOE,INVALID DRG
                                        95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
                                        95X2 = (C) MSP AMOUNT APPLIED INVALID
                                        95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
                                        95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
                                        95X5 = (C) MSP CODE = G/DATE BEFORE 1987
                                        95X6 = (C) MSP CODE = X AND NOT AVOIDED
                                        95X7 = (C) MSP CODE VALID, CABG/PCOE
                                        96X1 = (C) OTHER AMOUNTS INVALID
                                        96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
                                        97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
                                        97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
                                        98X1 = (C) COINSURANCE INVALID
                                        98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
                                        98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
                                        98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
                                        99XX = (D) POSS DUPE, PART B DOC-ID
                                        9901 = (C) REV CODE INVALID OR TRAILER CNT=0
                                        9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
                                        9903 = (C) NO CLINIC VISITS FOR RHC
                                        9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
                                        991X = (C) NO DATE OF SERVICE
                                        9910 = (C) EDIT 9910 (NEW)
                                        9911 = (C) BLOOD VERIFIED INVALID
                                        9920 = (C) EDIT 9920 (NEW)
                                        9930 = (C) EDIT 9930 (NEW)
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                              9931 = (C) OUTPAT COINSURANCE VALUES
                              9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
                              9940 = (C) EDIT 9940 (NEW)
                              9942 = (C) EDIT 9942 (NEW)
                              9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
                              9945 = (C) SERVICE DATE < 98001
                              9946 = (C) INVALID DIAGNOSIS CODE
                              9947 = (C) INVALID DIAGNOSIS CODE
                              9948 = (C) STAY FROM>96365,DIAG=V725
                              9960 = (C) MED CHOICE BUT HMO DATA MISSING
                              9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
                              9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER


  1   NCH_IP_PRO_APRVL_TYPE_TB              NCH INPATIENT PEER REVIEW ORGANIZATION APPROVAL TYPE TABLE
      ------------------------              ---------------------------------------------------------


                              1 = APPROVED BY THE PRO AS BILLED - CODE
                                  INDICATES THAT THE CLAIM HAS BEEN
                                  REVIEWED BY THE PRO AND HAS BEEN FULLY
                                  APPROVED INCLUDING ANY DAY OR COST
                                  OUTLIERS.
                              2 = AUTOMATIC APPROVAL - DOES NOT APPLY TO
                                  MEDICARE CLAIM.
                              3 = PARTIAL APPROVAL - CODE INDICATES THE
                                  BILL HAS BEEN REVIEWED BY THE PRO, AND
                                  SOME PORTION (DAYS OR SERVICES) HAS
                                  BEEN DENIED.  THE FROM/THRU DATES OF
                                  THE APPROVED PORTION OF THE STAY,
                                  EXCLUDING GRACE DAYS AND ANY PERIOD AT
                                  A NONCOVERED LEVEL OF CARE ARE SHOWN
                                  ON THE BILL.
                              4 = ADMISSION DENIED - CODE INDICATES THE
                                  PATIENT'S NEED FOR INPATIENT SERVICES
                                  WAS REVIEWED UPON ADMISSION AND THE
                                  PRO FOUND THAT THE STAY WAS NOT
                                  MEDICALLY NECESSARY.
                              5 = POST PAYMENT REVIEW - CODE INDICATES
                                  THAT ANY MEDICAL REVIEW WILL BE
                                  COMPLETED AFTER THE CLAIM IS PAID.
                                  THE BILL MAY BE A DAY OUTLIER, PART OF
                                  THE SAMPLE REVIEW, OR MAY NOT BE
                                  REVIEWED.
                              6 = PRE-ADMISSION AUTHORIZATION - PRE-
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                               ADMISSION AUTHORIZATION OBTAINED, BUT
                               SERVICES NOT REVIEWED BY THE PRO.
                          7 THRU 9 = RESERVED.

  1     NCH_NEAR_LINE_RIC_TB                  NCH NEAR-LINE RECORD IDENTIFICATION CODE TABLE
        --------------------                  ----------------------------------------------


                          O = PART B PHYSICIAN/SUPPLIER CLAIM
                              RECORD (PROCESSED BY LOCAL CARRIERS;
                              CAN INCLUDE DMEPOS SERVICES)
                          V = PART A INSTITUTIONAL CLAIM RECORD
                              (INPATIENT (IP), SKILLED NURSING
                              FACILITY (SNF), CHRISTIAN SCIENCE
                              (CS), HOME HEALTH AGENCY (HHA), OR
                              HOSPICE)
                          W = PART B INSTITUTIONAL CLAIM RECORD
                              (OUTPATIENT (OP), HHA)
                          U = BOTH PART A AND B INSTITUTIONAL HOME
                              HEALTH AGENCY (HHA) CLAIM RECORDS --
                              DUE TO HHPPS AND HHA A/B SPLIT.
                              (EFFECTIVE 10/00)
                          M = PART B DMEPOS CLAIM RECORD (PROCESSED
                              BY DME REGIONAL CARRIER) (EFFECTIVE 10/93)


  1     NCH_PATCH_TB                                    NCH PATCH TABLE
        ------------                                    ---------------


                          01 = RRB CATEGORY EQUATABLE BIC - CHANGED (ALL
                               CLAIM TYPES) -- APPLIED DURING THE NEARLINE
                               'G' CONVERSION TO CLAIMS WITH NCH WEEKLY
                               PROCESS DATE BEFORE 3/91.   PRIOR TO VERSION
                               'H', PATCH INDICATOR STORED IN REDEFINED CLAIM
                               EDIT GROUP, 3RD OCCURRENCE, POSITION 2.
                          02 = CLAIM TRANSACTION CODE MADE CONSISTENT WITH
                               NCH PAYMENT/EDIT RIC CODE (OP AND HHA) --
                               EFFECTIVE 3/94, CWFMQA BEGAN PATCH.  DURING
                               'H' CONVERSION, PATCH APPLIED TO CLAIMS WITH
                               NCH WEEKLY PROCESS DATE PRIOR TO 3/94.   PRIOR
                               TO VERSION 'H', PATCH INDICATOR STORED IN
                               REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE,
                               POSITION 1.
                          03 = GARBAGE/NONNUMERIC CLAIM TOTAL CHARGE AMOUNT
```

```
                            SET TO ZEROES (INSTNL) --  DURING THE VERSION
                            'G' CONVERSION, ERROR OCCURRED IN THE DERIVA-
                            TION OF THIS FIELD WHERE THE CLAIM WAS MISSING
                            REVENUE CENTER CODE = '0001'.   IN 1994, PATCH
                            WAS APPLIED TO THE OP AND HHA SAFS ONLY. (THIS
                            SAF PATCH INDICATOR WAS STORED IN THE REDEFINED
                            CLAIM EDIT GROUP, 4TH OCCURRENCE, POSITION 2).
                            DURING THE 'H' OCNVERSION, PATCH APPLIED TO
                            NEARLINE CLAIMS WHERE GARBAGE OR NONNUMERIC
                            VALUES.
                     04 = INCORRECT BENE RESIDENCE SSA STANDARD COUNTY
                            CODE '999' CHANGED (ALL CLAIM TYPES) --
                            APPLIED DURING THE NEARLINE 'G' CONVERSION AND
                            ONGOING THROUGH 4/21/94, CALLING EQSTZIP
                            ROUTINE TO CLAIMS WITH NCH WEEKLY PROCESS
                            DATE PRIOR TO 4/22/94.  PRIOR TO VERSION 'H'
                            PATCH INDICATOR STORED IN REDEFINED CLAIM
                            EDIT GROUP, 3RD OCCURRENCE, POSITION 4.
                     05 = WRONG CENTURY BENE BIRTH DATE CORRECTED (ALL
                            CLAIM TYPES) -- APPLIED DURING NEARLINE 'H'
                            CONVERSION TO ALL HISTORY WHERE CENTURY
                            GREATER THAN 1700 AND LESS THAN 1850; IF
                            CENTURY LESS THAN 1700, ZEROES MOVED.
                     06 = INCONSISTENT CWF BENE MEDICARE STATUS CODE
                            MADE CONSISTENT WITH AGE (ALL CLAIM TYPES) --
                            APPLIED DURING NEARLINE 'H' CONVERSION TO ALL
                            HISTORY AND PATCHED ONGOING.  BENE AGE IS
                            CALCULATED TO DETERMINE THE CORRECT VALUE;
                            IF GREATER THAN 64, 1ST POSITION MSC ='1';
                            IF LESS THAN 65, 1ST POSITION MSC = '2'.
                     07 = MISSING CWF BENE MEDIARE STATUS CODE DERIVED
                            (ALL CLAIM TYPES) -- APPLIED DURING NEARLINE
                            'H' CONVERSION TO ALL HISTORY AND PATCHED
                            ONGOING, EXCEPT CLAIMS WITH UNKNOWN DOB AND/
                            OR CLAIM FROM DATE='0' (LEFT BLANK).   BENE
                            AGE IS CALCULATED TO DETERMINE MISSING VALUE;
                            IF GREATER THAN 64, MSC='10'; IF LESS THAN
                            65, MSC = '20'.
                     08 = INVALID NCH PRIMARY PAYER CODE SET TO BLANKS
                            (INSTNL) -- APPLIED DURING VERSION 'H' CON-
                            VERSION TO CLAIMS WITH NCH WEEKLY PROCESS
                            DATE 10/1/93-10/30/95, WHERE MSP VALUES =
     1        NCH_PATCH_TB                          NCH PATCH TABLE
              ------------                          ---------------
```

```
                        INVALID '0', '1', '2', '3' OR '4' (CAUSED
                        BY ERRONEOUS LOGIC IN HCFA PROGRAM CODE,
                        WHICH WAS CORRECTED ON 11/1/95).
                 09 = ZERO CWF CLAIM ACCRETION DATE REPLACED WITH
                        NCH WEEKLY PROCESS DATE (ALL CLAIM TYPES)
                        -- APPLIED DURING VERSION 'H' CONVERSION TO
                        INSTNL AND DMERC CLAIMS; APPLIED DURING
                        VERSION 'G' CONVERSION TO NON-INSTITUTIONAL
                        (NON-DMERC) CLAIMS.  PRIOR TO VERSION 'H',
                        PATCH INDICATOR STORED IN REDEFINED CLAIM
                        EDIT GROUP, 3RD OCCURRENCE, POSITION 1.
                 10 = MULTIPLE REVENUE CENTER 0001 (OUTPATIENT,
                        HHA AND HOSPICE) -- PATCH APPLIED TO 1998 &
                        1999 NEARLINE AND SAFS TO DELETE ANY REVENUE
                        CODES THAT FOLLOWED THE FIRST '0001' REVENUE
                        CENTER CODE.   THE EDIT WAS APPLIED ACROSS ALL
                        INSTITUTIONAL CLAIM TYPES, INCLUDING INPATIENT/
                        SNF (THE PROBLEM WAS ONLY FOUND WITH OP/HHA/
                        HOSPICE CLAIMS).  THE PROBLEM WAS CORRECTED
                        6/25/99.
                 11 = TRUNCATED CLAIM TOTAL CHARGE AMOUNT IN THE
                        FIXED PORTION REPLACED WITH THE TOTAL CHARGE
                        AMOUNT IN THE REVENUE CENTER 0001 AMOUNT FIELD
                        -- SERVICE YEARS 1998 & 1999 PATCHED DURING
                        QUARTERLY MERGE.  THE 1998 & 1999 SAFS WERE
                        CORRECTED WHEN FINALIZED IN 7/99.  THE PATCH
                        WAS DONE FOR RECORDS WITH NCH DAILY PROCESS
                        DATE 1/4/99 - 5/14/99.
                 12 = MISSING CLAIM-LEVEL HHA TOTAL VISIT COUNT --
                        SERVICE YEARS 1998, 1999 & 2000 PATCH APPLIED
                        DURING VERSION 'I' CONVERSION OF BOTH THE
                        NEARLINE AND SAFS.   PROBLEM OCCURS IN THOSE
                        CLAIMS RECOVERED DURING THE MISSING CLAIMS
                        EFFORT.
                 13 = INCONSISTENT CLAIM MCO PAID SWITCH MADE CONSISTENT
                        WITH CRITERIA USED TO IDENTIFY AN INPATIENT
                        ENCOUNTER CLAIM -- IF MCO PAID SWITCH EQUAL TO BLANK
                        OR '0' AND ALL CONDITIONS ARE MET TO INDICATE AN
                        INPATIENT ENCOUNTER CLAIM (BENE ENROLLED IN A RISK
                        MCO DURING THE SERVICE PERIOD), CHANGE THE SWITCH TO
                        A '1'.  THE PATCH WAS APPLIED DURING THE VERSION 'I'
                        CONVERSION, FOR CLAIMS BACK TO 7/1/97 SERVICE THRU DATE.
```

```
1       NCH_STATE_SGMT_TB                              NCH STATE SEGMENT TABLE
        -----------------                              -----------------------


                             01 = ALABAMA
                             02 = ALASKA
                             03 = ARIZONA
                             04 = ARKANSAS
                             05 = CALIFORNIA
                             06 = COLORADO
                             07 = CONNECTICUT
                             08 = DELAWARE
                             09 = DISTRICT OF COLUMBIA
                             10 = FLORIDA
                             11 = GEORGIA
                             12 = HAWAII
                             13 = IDAHO
                             14 = ILLINOIS
                             15 = INDIANA
                             16 = IOWA
                             17 = KANSAS
                             18 = KENTUCKY
                             19 = LOUISIANA
                             20 = MAINE
                             21 = MARYLAND
                             22 = MASSACHUSETTS
                             23 = MICHIGAN
                             24 = MINNESOTA
                             25 = MISSISSIPPI
                             26 = MISSOURI
                             27 = MONTANA
                             28 = NEBRASKA
                             29 = NEVADA
                             30 = NEW HAMPSHIRE
                             31 = NEW JERSEY
                             32 = NEW MEXICO
                             33 = NEW YORK
                             34 = NORTH CAROLINA
                             35 = NORTH DAKOTA
                             36 = OHIO
                             37 = OKLAHOMA
                             38 = OREGON
                             39 = PENNSYLVANIA
                             40 = PUERTO RICO
```

```
                                   41 = RHODE ISLAND
                                   42 = SOUTH CAROLINA
                                   43 = SOUTH DAKOTA
                                   44 = TENNESEE
                                   45 = TEXAS
                                   46 = UTAH
                                   47 = VERMONT
                                   48 = VIRGIN ISLANDS
                                   49 = VIRGINIA
                                   50 = WASHINGTON
                                   51 = WEST VIRGINIA
                                   52 = WISCONSIN
                                   53 = WYOMING
                                   54 = AFRICA
                                   55 = ASIA
                                   56 = CANADA
                                   57 = CENTRAL AMERICA & WEST INDIES
1      NCH_STATE_SGMT_TB                              NCH STATE SEGMENT TABLE
       -----------------                              -----------------------

                                   58 = EUROPE
                                   59 = MEXICO
                                   60 = OCEANIA
                                   61 = PHILIPPINES
                                   62 = SOUTH AMERICA
                                   63 = US POSSESSIONS
                                   97 = SAIPAN - MP
                                   98 = GUAM
                                   99 = AMERICAN SAMOA


1      PRVDR_NUM_TB                                   PROVIDER NUMBER TABLE
       ------------                                   ---------------------



       -    FIRST TWO POSITIONS ARE THE GEO SSA STATE CODE.
              EXCEPTION: 55 = CALIFORNIA
                         67 = TEXAS
                         68 = FLORIDA


       -    POSITIONS 3 AND SOMETIMES 4 ARE USED AS A
              CATEGORY IDENTIFIER.  THE REMAINING POSITIONS
              ARE SERIAL NUMBERS.  THE FOLLOWING BLOCKS OF NUMBERS
              ARE RESERVED FOR THE FACILITIES INDICATED (NOTE:
              MAY HAVE DIFFERENT MEANINGS DEPENDENT ON THE TYPE
```

```
                    OF BILL (TOB):

0001-0879    SHORT-TERM (GENERAL AND SPECIALTY)
             HOSPITALS WHERE TOB = 11X; ESRD
             CLINIC WHERE TOB = 72X
0880-0899    RESERVED FOR HOSPITALS PARTICIPATING
             IN ORD DEMONSTRATION PROJECTS WHERE
             TOB = 11X; ESRD CLINIC WHERE TOB =
             72X
0900-0999    MULTIPLE HOSPITAL COMPONENT IN A
             MEDICAL COMPLEX (NUMBERS RETIRED)
             WHERE TOB = 11X; ESRD CLINIC WHERE
             TOB = 72X
1000-1199    RESERVED FOR FUTURE USE
1200-1224    ALCOHOL/DRUG HOSPITALS (EXCLUDED
             FROM PPS-NUMBERS RETIRED)
             WHERE TOB = 11X; ESRD CLINIC WHERE
             TOB = 72X
1225-1299    MEDICAL ASSISTANCE FACILITIES
             (MONTANA PROJECT); ESRD CLINIC WHERE
             TOB = 72X
1300-1399    RURAL PRIMARY CARE HOSPITAL (RCPH) -
             EFF. 10/97 CHANGED TO CRITICAL ACCESS
             HOSPITALS (CAH)
1400-1499    CONTINUATION OF 4900-4999 SERIES (CMHC)
1500-1799    HOSPICES
1800-1989    FEDERALLY QUALIFIED HEALTH CENTERS
             (FQHC) WHERE TOB = 73X; SNF (IP PTB)
             WHERE TOB = 22X; HHA WHERE TOB = 32X,
             33X, 34X
1990-1999    CHRISTIAN SCIENCE SANATORIA
             (HOSPITAL SERVICES)
2000-2299    LONG-TERM HOSPITALS (EXCLUDED FROM PPS)
2300-2499    CHRONIC RENAL DISEASE FACILITIES
             (HOSPITAL BASED)
2500-2899    NON-HOSPITAL RENAL DISEASE
             TREATMENT CENTERS
2900-2999    INDEPENDENT SPECIAL PURPOSE RENAL
             DIALYSIS FACILITY (1)
3000-3024    FORMERLY TUBERCULOSIS HOSPITALS
             (NUMBERS RETIRED)
3025-3099    REHABILITATION HOSPITALS (EXCLUDED
             FROM PPS)
3100-3199    CONTINUATION OF SUBUNITS OF NONPROFIT
```

```
                                         AND PROPRIETARY HOME HEALTH AGENCIES
                                         (7300-7399) SERIES (3) (EFF. 4/96)
                             3200-3299   CONTINUATION OF 4800-4899 SERIES (CORF)
  1         PRVDR_NUM_TB                      PROVIDER NUMBER TABLE
            ------------                      ---------------------

                             3300-3399   CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
                                         WHERE TOB = 11X; ESRD CLINIC WHERE TOB =
                                         72X
                             3400-3499   CONTINUATION OF RURAL HEALTH CLINICS
                                         (PROVIDER-BASED) (3975-3999)
                             3500-3699   RENAL DISEASE TREATMENT CENTERS
                                         (HOSPITAL SATELLITES)
                             3700-3799   HOSPITAL BASED SPECIAL PURPOSE RENAL
                                         DIALYSIS FACILITY (1)
                             3800-3974   RURAL HEALTH CLINICS (FREE-STANDING)
                             3975-3999   RURAL HEALTH CLINICS (PROVIDER-BASED)
                             4000-4499   PSYCHIATRIC HOSPITALS (EXCLUDED
                                         FROM PPS)
                             4500-4599   COMPREHENSIVE OUTPATIENT
                                         REHABILITATION FACILITIES (CORF)
                             4600-4799   COMMUNITY MENTAL HEALTH CENTERS (CMHC);
                                         9/30/91 - 3/31/97 USED FOR CLINIC OPT
                                         WHERE TOB = 74X
                             4800-4899   CONTINUATION OF 4500-4599 SERIES (CORF)
                                          (EFF. 10/95)
                             4900-4999   CONTINUATION OF 4600-4799 SERIES (CMHC)
                                         (EFF. 10/95); 9/30/91 - 3/31/97 USED FOR
                                         CLINIC OPT WHERE TOB = 74X
                             5000-6499   SKILLED NURSING FACILITIES
                             6500-6989   CMHC / OUTPATIENT PHYSICAL THERAPY SERVICES
                                         WHERE TOB = 74X; CORF WHERE TOB =
                                         75X
                             6990-6999   CHRISTIAN SCIENCE SANATORIA (SKILLED
                                         NURSING SERVICES)
                             7000-7299   HOME HEALTH AGENCIES (HHA) (2)
                             7300-7399   SUBUNITS OF 'NONPROFIT' AND
                                         'PROPRIETARY' HOME HEALTH AGENCIES (3)
                             7400-7799   CONTINUATION OF 7000-7299 SERIES
                             7800-7999   SUBUNITS OF STATE AND LOCAL GOVERNMENTAL
                                         HOME HEALTH AGENCIES (3)
                             8000-8499   CONTINUATION OF 7400-7799 SERIES (HHA)
                             8500-8899   CONTINUATION OF RURAL HEALTH
                                         CENTER (PROVIDER BASED) (3400-3499)
```

```
                              8900-8999   CONTINUATION OF RURAL HEALTH
                                          CENTER (FREE-STANDING) (3800-3974)
                              9000-9499   CONTINUATION OF 8000-8499 SERIES (HHA)
                                          (EFF. 10/95)
                              9500-9999   RESERVED FOR FUTURE USE (EFF. 8/1/98)
                                          NOTE: 10/95-7/98 THIS SERIES WAS
                                          ASSIGNED TO HHA'S BUT RESCINDED - NO
                                          HHA'S WERE EVER ASSIGNED A NUMBER
                                          FROM THIS SERIES.

                              EXCEPTION:

                              P001-P999   ORGAN PROCUREMENT ORGANIZATION

                          (1) THESE FACILITIES (SPRDFS) WILL BE ASSIGNED
                              THE SAME PROVIDER NUMBER WHENEVER THEY
                              ARE RECERTIFIED.

                          (2) THE 6400-6499 SERIES OF PROVIDER NUMBERS
                              IN IOWA (16), SOUTH DAKOTA (43) AND TEXAS (45)
```

```
1        PRVDR_NUM_TB                             PROVIDER NUMBER TABLE
         ------------                             ---------------------

                              HAVE BEEN USED IN REDUCING ACUTE CARE COSTS (RACC)
                              EXPERIMENTS.

                          (3) IN VIRGINIA (49), THE SERIES 7100-7299 HAS
                              BEEN RESERVED FOR STATEWIDE SUBUNIT COMPONENTS
                              OF THE VIRGINIA STATE HOME HEALTH AGENCIES.

                          (4) PARENT AGENCY MUST HAVE A NUMBER IN THE
                              7000-7299, 7400-7799 OR 8000-8499 SERIES.

                         NOTE:
                           THERE IS A SPECIAL NUMBERING SYSTEM FOR UNITS
                           OF HOSPITALS THAT ARE EXCLUDED FROM PROSPECTIVE
                           PAYMENT SYSTEM (PPS) AND HOSPITALS WITH SNF
                           SWING-BED DESIGNATION.  AN ALPHA CHARACTER IN
                           THE THIRD POSITION OF THE PROVIDER NUMBER
                           IDENTIFIES THE TYPE OF UNIT OR SWING-BED
                           DESIGNATION AS FOLLOWS:

                             S = PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
                             T = REHABILITATION UNIT (EXCLUDED FROM PPS)
```

```
                         U = SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
                         V = ALCOHOL DRUG UNIT (PRIOR TO 10/87 ONLY)
                         W = LONG TERM SNF SWING-BED HOSPITAL
                             (EFF 3/91)
                         Y = REHAB HOSPITAL SWING-BED (EFF 9/92)
                         Z = RURAL PRIMARY CARE SWING-BED HOSPITAL

                       THERE IS ALSO A SPECIAL NUMBERING SYSTEM FOR
                       ASSIGNING EMERGENCY HOSPITAL IDENTIFICATION
                       NUMBERS (NON PARTICIPATING HOSPITALS).  THE
                       SIXTH POSITION OF THE PROVIDER NUMBER IS AS
                       FOLLOWS:

                         E = NON-FEDERAL EMERGENCY HOSPITAL
                         F = FEDERAL EMERGENCY HOSPITAL
```

1   PTNT_DSCHRG_STUS_TB   PATIENT DISCHARGE STATUS TABLE
      -------------------   ------------------------------

```
                       01 = DISCHARGED TO HOME/SELF CARE (ROUTINE
                            CHARGE).
                       02 = DISCHARGED/TRANSFERRED TO OTHER SHORT TERM
                            GENERAL HOSPITAL FOR INPATIENT CARE.
                       03 = DISCHARGED/TRANSFERRED TO SKILLED
                            NURSING FACILITY (SNF) - (FOR HOSPITALS
                            WITH AN APPROVED SWING BED ARRANGEMENT,
                            USE CODE 61 - SWING BED.  FOR REPORTING
                            DISCHARGES/TRANSFERS TO A NON-CERTIFIED
                            SNF, THE HOSPITAL MUST USE CODE 04 - ICF.
                       04 = DISCHARGED/TRANSFERRED TO INTERMEDIATE
                            CARE FACILITY (ICF).
                       05 = DISCHARGED/TRANSFERRED TO ANOTHER TYPE
                            OF INSTITUTION FOR INPATIENT CARE (INCLUDING
                            DISTINCT PARTS).
                       06 = DISCHARGED/TRANSFERRED TO HOME CARE OF
                            ORGANIZED HOME HEALTH SERVICE ORGANIZATION.
                       07 = LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED
                            CARE.
                       08 = DISCHARGED/TRANSFERRED TO HOME UNDER
                            CARE OF A HOME IV DRUG THERAPY PROVIDER.
                       09 = ADMITTED AS AN INPATIENT TO THIS
                            HOSPITAL (EFFECTIVE 3/1/91).  IN SITUA-
                            TIONS  WHERE A PATIENT IS ADMITTED BEFORE
```

```
                        MIDNIGHT OF THE THIRD DAY FOLLOWING THE
                        DAY OF AN OUTPATIENT SERVICE, THE OUT-
                        PATIENT SERVICES ARE CONSIDERED INPATIENT.
                   20 = EXPIRED (DID NOT RECOVER - CHRISTIAN
                        SCIENCE PATIENT).
                   30 = STILL PATIENT.
                   40 = EXPIRED AT HOME (HOSPICE CLAIMS ONLY)
                   41 = EXPIRED IN A MEDICAL FACILITY SUCH AS
                        HOSPITAL, SNF, ICF, OR FREESTANDING
                        HOSPICE. (HOSPICE CLAIMS ONLY)
                   42 = EXPIRED - PLACE UNKNOWN (HOSPICE CLAIMS
                        ONLY)
                   50 = HOSPICE - HOME (EFF. 10/96)
                   51 = HOSPICE - MEDICAL FACILITY (EFF. 10/96)
                   61 = DISCHARGED/TRANSFERRED WITHIN THIS INSTI-
                        TUTION TO A HOSPITAL-BASED MEDICARE
                        APPROVED SWING BED (TO BE IMPLEMENTED IN
                        1999)
                   71 = DISCHARGED/TRANSFERRED/REFERRED TO ANOTHER
                        INSTITUTION FOR OUTPATIENT SERVICES AS
                        SPECIFIED BY THE DISCHARGE PLAN OF CARE (TO
                        BE IMPLEMENTED IN 1999).
                   72 = DISCHARGED/TRANSFERRED/REFERRED TO THIS
                        INSTITUTION FOR OUTPATIENT SERVICES AS
                        SPECIFIED BY THE DISCHARGE PLAN OF CARE
                        (TO BE IMPLEMENTED IN 1999).


  1       REV_CNTR_ANSI_TB                   REVENUE CENTER ANSI CODE TABLE
          ----------------                   ------------------------------


                   *******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
                   **************POSITIONS 1 & 2 OF ANSI CODE**************
                   CO = CONTRACTUAL OBLIGATIONS -- THIS GROUP CODE SHOULD
                        BE USED WHEN A CONTRACTUAL AGREEMENT BETWEEN THE
                        PAYER AND PAYEE, OR A REGULATORY REQUIREMENT, RE-
                        SULTED IN AN ADJUSTMENT.  GENERALLY, THESE ADJUST-
                        MENTS ARE CONSIDERED A WRITE-OFF FOR THE PROVIDER
                        AND ARE NOT BILLED TO THE PATIENT.

                   CR = CORRECTIONS AND REVERSALS -- THIS GROUP CODE SHOULD
                        BE USED FOR CORRECTING A PRIOR CLAIM.  IT APPLIES
                        WHEN THERE IS A CHANGE TO A PREVIOUSLY ADJUDICATED
                        CLAIM.
```

```
          OA = OTHER ADJUSTMENTS -- THIS GROUP CODE SHOULD BE USED
               WHEN NO OTHER GROUP CODE APPLIES TO THE ADJUSTMENT.

          PI = PAYER INITIATED REDUCTIONS -- THIS GROUP CODE SHOULD
               BE USED WHEN, IN THE OPINION OF THE PAYER, THE ADJUST-
               MENT IS NOT THE RESPONSIBILITY OF THE PATIENT, BUT
               THERE IS NO SUPPORTING CONTRACT BETWEEN THE PROVIDER
               AND THE PAYER (I.E., MEDICAL REVIEW OR PROFESSIONAL
               REVIEW ORGANIZATION ADJUSTMENTS).

          PR = PATIENT RESPONSIBILITY -- THIS GROUP SHOULD BE USED
               WHEN THE ADJUSTMENT REPRESENTS AN AMOUNT THAT SHOULD
               BE BILLED TO THE PATIENT OR INSURED.  THIS GROUP
               WOULD TYPICALLY BE USED FOR DEDUCTIBLE AND COPAY
               ADJUSTMENTS.

          ***********CLAIM ADJUSTMENT REASON CODES***************
          ***********POSITIONS 3 THROUGH 5 OF ANSI CODE**********

          1 = DEDUCTIBLE AMOUNT
          2 = COINSURANCE AMOUNT
          3 = CO-PAY AMOUNT
          4 = THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER
              USED OR A REQUIRED MODIFIER IS MISSING.
          5 = THE PROCEDURE CODE/BILL TYPE IS INCONSISTENT WITH THE
              PLACE OF SERVICE.
          6 = THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S
              AGE.
          7 = THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S
              GENDER.
          8 = THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER
              TYPE.
          9 = THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.
          10 = THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S
               GENDER.
          11 = THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE.
          12 = THE DIAGNOSIS IS INCONSISTENT WITH THE PROVIDER TYPE.
          13 = THE DATE OF DEATH PRECEDES THE DATE OF SERVICE.
          14 = THE DATE OF BIRTH FOLLOWS THE DATE OF SERVICE.
          15 = CLAIM/SERVICE ADJUSTED BECAUSE THE SUBMITTED AUTH-
               ORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT
               APPLY TO THE BILLED SERVICES OR PROVIDER.
          16 = CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR
```

```
1       REV_CNTR_ANSI_TB                            REVENUE CENTER ANSI CODE TABLE
        ----------------                            ------------------------------
                                    ADJUDICATION.
                               17 = CLAIM/SERVICE ADJUSTED BECAUSE REQUESTED INFORMATION
                                    WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE.
                               18 = DUPLICATE CLAIM/SERVICE.
                               19 = CLAIM DENIED BECAUSE THIS IS A WORK-RELATED INJURY/
                                    ILLNESS AND THUS THE LIABILITY OF THE WORKER'S COM-
                                    PENSATION CARRIER.
                               20 = CLAIM DENIED BECAUSE THIS INJURY/ILLNESS IS COVERED
                                    BY THE LIABILITY CARRIER.
                               21 = CLAIM DENIED BECAUSE THIS INJURY/ILLNESS IS THE
                                    LIABILITY OF THE NO-FAULT CARRIER.
                               22 = CLAIM ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY
                                    ANOTHER PAYER PER COORDINATION OF BENEFITS.
                               23 = CLAIM ADJUSTED BECAUSE CHARGES HAVE BEEN PAID BY
                                    ANOTHER PAYER.
                               24 = PAYMENT FOR CHARGES ADJUSTED.  CHARGES ARE COVERED
                                    UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.
                               25 = PAYMENT DENIED.  YOUR STOP LOSS DEDUCTIBLE HAS NOT
                                    BEEN MET.
                               26 = EXPENSES INCURRED PRIOR TO COVERAGE.
                               27 = EXPENSES INCURRED AFTER COVERAGE TERMINATED.
                               28 = COVERAGE NOT IN EFFECT AT THE TIME THE SERVICE WAS
                                    PROVIDED.
                               29 = THE TIME LIMIT FOR FILING HAS EXPIRED.
                               30 = CLAIM/SERVICE ADJUSTED BECAUSE THE PATIENT HAS NOT MET
                                    THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR
                                    RESIDENCY REQUIREMENTS.
                               31 = CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR
                                    INSURED.
                               32 = OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN
                                    ELIGIBLE DEPENDENT AS DEFINED.
                               33 = CLAIM DENIED.  INSURED HAS NO DEPENDENT COVERAGE.
                               34 = CLAIM DENIED.  INSURED HAS NO COVERAGE FOR NEWBORNS.
                               35 = BENEFIT MAXIMUM HAS BEEN REACHED.
                               36 = BALANCE DOES NOT EXCEED COPAYMENT AMOUNT.
                               37 = BALANCE DOES NOT EXCEED DEDUCTIBLE AMOUNT.
                               38 = SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED
                                    (NETWORK) PROVIDERS.
                               39 = SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTI-
                                    FICATION WAS REQUESTED.
                               40 = CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY/URGENT
```

```
                                        CARE.
                         41 = DISCOUNT AGREED TO IN PREFERRED PROVIDER CONTRACT.
                         42 = CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE
                                AMOUNT.
                         43 = GRAMM-RUDMAN REDUCTION.
                         44 = PROMPT-PAY DISCOUNT.
                         45 = CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGE-
                                MENT.
                         46 = THIS (THESE) SERVICE(S) IS(ARE) NOT COVERED.
                         47 = THIS (THESE) DIAGNOSIS(ES) IS(ARE) NOT COVERED,
                                MISSING, OR ARE INVALID.
                         48 = THIS (THESE) PROCEDURE(S) IS(ARE) NOT COVERED.
                         49 = THESE ARE NON-COVERED SERVICES BECAUSE THIS IS A
                                ROUTINE EXAM OR SCREENING PROCEDURE DONE IN CONJUNC-
                                TION WITH A ROUTINE EXAM.
                         50 = THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT
                                DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
  1       REV_CNTR_ANSI_TB                        REVENUE CENTER ANSI CODE TABLE
          ----------------                        ------------------------------

                         51 = THESE ARE NON-COVERED SERVICES BECAUSE THIS A PRE-
                                EXISTING CONDITION.
                         52 = THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT
                                ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE
                                BILLED.
                         53 = SERVICES BY AN IMMEDIATE RELATIVE OR A MEMBER OF THE
                                SAME HOUSEHOLD ARE NOT COVERED.
                         54 = MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS
                                CASE.
                         55 = CLAIM/SERVICE DENIED BECAUSE PROCEDURE/TREATMENT IS
                                DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER.
                         56 = CLAIM/SERVICE DENIED BECAUSE PROCEDURE/TREATMENT HAS
                                NOT BEEN DEEMED 'PROVEN TO BE EFFECTIVE' BY PAYER.
                         57 = CLAIM/SERVICE ADJUSTED BECAUSE THE PAYER DEEMS THE
                                INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF
                                SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, OR
                                THIS DOSAGE.
                         58 = CLAIM/SERVICE ADJUSTED BECAUSE TREATMENT WAS DEEMED BY
                                THE PAYER TO HAVE BEEN RENDERED IN AN INAPPROPRIATE
                                OR INVALID PLACE OF SERVICE.
                         59 = CHARGES ARE ADJUSTED BASED ON MULTIPLE SURGERY RULES OR
                                CONCURRENT ANESTHESIA RULES.
                         60 = CHARGES FOR OUTPATIENT SERVICES WITH THE PROXIMITY TO
                                INPATIENT SERVICES ARE NOT COVERED.
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                        61 = CHARGES ADJUSTED AS PENALTY FOR FAILURE TO OBTAIN SECOND
                             SURGICAL OPINION.
                        62 = CLAIM/SERVICE DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED,
                             PRECERTIFICATION/AUTHORIZATION.
                        63 = CORRECTION TO A PRIOR CLAIM. INACTIVE
                        64 = DENIAL REVERSED PER MEDICAL REVIEW. INACTIVE
                        65 = PROCEDURE CODE WAS INCORRECT.  THIS PAYMENT REFLECTS THE
                             CORRECT CODE. INACTIVE
                        66 = BLOOD DEDUCTIBLE.
                        67 = LIFETIME RESERVE DAYS. INACTIVE
                        68 = DRG WEIGHT. INACTIVE
                        69 = DAY OUTLIER AMOUNT.
                        70 = COST OUTLIER AMOUNT.
                        71 = PRIMARY PAYER AMOUNT.
                        72 = COINSURANCE DAY. INACTIVE
                        73 = ADMINISTRATIVE DAYS. INACTIVE
                        74 = INDIRECT MEDICAL EDUCATION ADJUSTMENT.
                        75 = DIRECT MEDICAL EDUCATION ADJUSTMENT.
                        76 = DISPROPORTIONATE SHARE ADJUSTMENT.
                        77 = COVERED DAYS. INACTIVE
                        78 = NON-COVERED DAYS/ROOM CHARGE ADJUSTMENT.
                        79 = COST REPORT DAYS. INACTIVE
                        80 = OUTLIER DAYS. INACTIVE
                        81 = DISCHARGES. INACTIVE
                        82 = PIP DAYS. INACTIVE
                        83 = TOTAL VISITS. INACTIVE
                        84 = CAPITAL ADJUSTMENTS. INACTIVE
                        85 = INTEREST AMOUNT. INACTIVE
                        86 = STATUTORY ADJUSTMENT. INACTIVE
                        87 = TRANSFER AMOUNTS.
                        88 = ADJUSTMENT AMOUNT REPRESENTS COLLECTION AGAINST
                             RECEIVABLE CREATED IN PRIOR OVERPAYMENT.
                        89 = PROFESSIONAL FEES REMOVED FROM CHARGES.
                        90 = INGREDIENT COST ADJUSTMENT.
  1      REV_CNTR_ANSI_TB                       REVENUE CENTER ANSI CODE TABLE
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                        91 = DISPENSING FEE ADJUSTMENT.
                        92 = CLAIM PAID IN FULL. INACTIVE
                        93 = NO CLAIM LEVEL ADJUSTMENT. INACTIVE
                        94 = PROCESS IN EXCESS OF CHARGES.
                        95 = BENEFITS ADJUSTED.  PLAN PROCEDURES NOT FOLLOWED.
                        96 = NON-COVERED CHARGES.
                        97 = PAYMENT IS INCLUDED IN ALLOWANCE FOR ANOTHER
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                      SERVICE/PROCEDURE.
             98 = THE HOSPITAL MUST FILE THE MEDICARE CLAIM FOR THIS
                  INPATIENT NON-PHYSICIAN SERVICE. INACTIVE
             99 = MEDICARE SECONDARY PAYER ADJUSTMENT AMOUNT. INACTIVE
            100 = PAYMENT MADE TO PATIENT/INSURED/RESPONSIBLE PARTY.
            101 = PREDETERMINATION: ANTICIPATED PAYMENT UPON COMPLE-
                  TION OF SERVICES OR CLAIM AJUDICATION.
            102 = MAJOR MEDICAL ADJUSTMENT.
            103 = PROVIDER PROMOTIONAL DISCOUNT (I.E. SENIOR CITIZEN
                  DISCOUNT).
            104 = MANAGED CARE WITHHOLDING.
            105 = TAX WITHHOLDING.
            106 = PATIENT PAYMENT OPTION/ELECTION NOT IN EFFECT.
            107 = CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING
                  CLAIM/SERVICE WAS NOT PAID OR IDENTIFIED ON THE CLAIM.
            108 = CLAIM/SERVICE REDUCED BECAUSE RENT/PURCHASE GUIDELINES
                  WERE NOT MET.
            109 = CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR.  YOU MUST
                  SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR.
            110 = BILLING DATE PREDATES SERVICE DATE.
            111 = NOT COVERED UNLESS THE PROVIDER ACCEPTS ASSIGNMENT.
            112 = CLAIM/SERVICE ADJUSTED AS NOT FURNISHED DIRECTLY
                  TO THE PATIENT AND/OR NOT DOCUMENTED.
            113 = CLAIM DENIED BECAUSE SERVICE/PROCEDURE WAS PROVIDED
                  OUTSIDE THE UNITED STATES OR AS A RESULT OF WAR.
            114 = PROCEDURE/PRODUCT NOT APPROVED BY THE FOOD AND DRUG
                  ADMINISTRATION.
            115 = CLAIM/SERVICE ADJUSTED AS PROCEDURE POSTPONED OR
                  CANCELED.
            116 = CLAIM/SERVICE DENIED.  THE ADVANCE INDEMNIFICATION
                  NOTICE SIGNED BY THE PATIENT DID NOT COMPLY WITH
                  REQUIREMENTS.
            117 = CLAIM/SERVICE ADJUSTED BECAUSE TRANSPORTATION IS ONLY
                  COVERED TO THE CLOSEST FACILITY THAT CAN PROVIDE
                  THE NECESSARY CARE.
            118 = CHARGES REDUCED FOR ESRD NETWORK SUPPORT.
            119 = BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
            120 = PATIENT IS COVERED BY A MANAGED CARE PLAN. INACTIVE
            121 = INDEMNIFICATION ADJUSTMENT.
            122 = PSYCHIATRIC REDUCTION.
            123 = PAYER REFUND DUE TO OVERPAYMENT.  INACTIVE
            124 = PAYER REFUND AMOUNT - NOT OUR PATIENT. INACTIVE
            125 = CLAIM/SERVICE ADJUSTED DUE TO A SUBMISSION/BILLING
                  ERROR(S).
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                        126 = DEDUCTIBLE - MAJOR MEDICAL.
                        127 = COINSURANCE - MAJOR MEDICAL.
                        128 = NEWBORN'S SERVICES ARE COVERED IN THE MOTHER'S
                              ALLOWANCE.
                        129 = CLAIM DENIED - PRIOR PROCESSING INFORMATION APPEARS
                              INCORRECT.
                        130 = PAPER CLAIM SUBMISSION FEE.
 1      REV_CNTR_ANSI_TB                        REVENUE CENTER ANSI CODE TABLE
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                        131 = CLAIM SPECIFIC NEGOTIATED DISCOUNT.
                        132 = PREARRANGED DEMONSTRATION PROJECT ADJUSTMENT.
                        133 = THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING
                              FURTHER REVIEW.
                        134 = TECHNICAL FEES REMOVED FROM CHARGES.
                        135 = CLAIM DENIED.  INTERIM BILLS CANNOT BE PROCESSED.
                        136 = CLAIM ADJUSTED.  PLAN PROCEDURES OF A PRIOR PAYER
                              WERE NOT FOLLOWED.
                        137 = PAYMENT/REDUCTION FOR REGULATORY SURCHARGES, ASSESS-
                              MENTS, ALLOWANCES OR HEALTH RELATED TAXES.
                        138 = CLAIM/SERVICE DENIED.  APPEAL PROCEDURES NOT
                              FOLLOWED OR TIME LIMITS NOT MET.
                        139 = CONTRACTED FUNDING AGREEMENT - SUBSCRIBER IS EMPLOYED
                              BY THE PROVIDER OF SERVICES.
                        140 = PATIENT/INSURED HEALTH IDENTIFICATION NUMBER AND NAME
                              DO NOT MATCH.
                        141 = CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE
                              AND INELIGIBLE PERIODS OF COVERAGE.
                        142 = CLAIM ADJUSTED BY THE MONTHLY MEDICAID PATIENT
                              LIABILITY AMOUNT.
                        A0 = PATIENT REFUND AMOUNT
                        A1 = CLAIM DENIED CHARGES.
                        A2 = CONTRACTUAL ADJUSTMENT.
                        A3 = MEDICARE SECONDARY PAYER LIABILITY MET. INACTIVE
                        A4 = MEDICARE CLAIM PPS CAPITAL DAY OUTLIER AMOUNT.
                        A5 = MEDICARE CLAIM PPS CAPITAL COST OUTLIER AMOUNT.
                        A6 = PRIOR HOSPITALIZATION OR 30 DAY TRANSFER REQUIREMENT
                             NOT MET.
                        A7 = PRESUMPTIVE PAYMENT ADJUSTMENT.
                        A8 = CLAIM DENIED; UNGROUPABLE DRG.
                        B1 = NON-COVERED VISITS.
                        B2 = COVERED VISITS. INACTIVE
                        B3 = COVERED CHARGES. INACTIVE
                        B4 = LATE FILING PENALTY.
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                                    B5 = CLAIM/SERVICE ADJUSTED BECAUSE COVERAGE/PROGRAM
                                         GUIDELINES WERE NOT MET OR WERE EXCEEDED.
                                    B6 = THIS SERVICE/PROCEDURE IS ADJUSTED WHEN PERFORMED/
                                         BILLED BY THIS TYPE OF PROVIDER, BY THIS TYPE OF
                                         FACILITY, OR BY A PROVIDER OF THIS SPECIALTY.
                                    B7 = THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE
                                         PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF
                                         SERVICE.
                                    B8 = CLAIM/SERVICE NOT COVERED/REDUCED BECAUSE ALTER-
                                         NATIVE SERVICES WERE AVAILABLE, AND SHOULD HAVE
                                         BEEN UTILIZED.
                                    B9 = SERVICES NOT COVERED BECAUSE THE PATIENT IS EN-
                                         ROLLED IN A HOSPICE.
                                    B10 = ALLOWED AMOUNT HAS BEEN REDUCED BECAUSE A COM-
                                          PONENT OF THE BASIC PROCEDURE/TEST WAS PAID.  THE
                                          BENEFICIARY IS NOT LIABLE FOR MORE THAN THE CHARGE
                                          LIMIT FOR THE BASIC PROCEDURE/TEST.
                                    B11 = THE CLAIM/SERVICE HAS BEEN TRANSFERRED TO THE
                                          PROPER PAYER/PROCESSOR FOR PROCESSING.  CLAIM/
                                          SERVICE NOT COVERED BY THIS PAYER/PROCESSOR.
                                    B12 = SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RE-
                                          CORDS.
                                    B13 = PREVIOUSLY PAID.  PAYMENT FOR THIS CLAIM/SERVICE
                                          MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
 1      REV_CNTR_ANSI_TB                              REVENUE CENTER ANSI CODE TABLE
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                                    B14 = CLAIM/SERVICE DENIED BECAUSE ONLY ONE VISIT OR
                                          CONSULTATION PER PHYSICIAN PER DAY IS COVERED.
                                    B15 = CLAIM/SERVICE ADJUSTED BECAUSE THIS PROCEDURE/
                                          SERVICE IS NOT PAID SEPARATELY.
                                    B16 = CLAIM/SERVICE ADJUSTED BECAUSE 'NEW PATIENT'
                                          QUALIFICATIONS WERE NOT MET.
                                    B17 = CLAIM/SERVICE ADJUSTED BECAUSE THIS SERVICE WAS
                                          NOT PRESCRIBED BY A PHYSICIAN, NOT PRESCRIBED
                                          PRIOR TO DELIVERY, THE PRESCRIPTION IS INCOMPLETE,
                                          OR THE PRESCRIPTION IS NOT CURRENT.
                                    B18 = CLAIM/SERVICE DENIED BECAUSE THIS PROCEDURE CODE/
                                          MODIFIER WAS INVALID ON THE DATE OF SERVICE OR
                                          CLAIM SUBMISSION.
                                    B19 = CLAIM/SERVICE ADJUSTED BECAUSE OF THE FINDING OF A
                                          REVIEW ORGANIZATION.  INACTIVE
                                    B20 = CHARGES ADJUSTED BECAUSE PROCEDURE/SERVICE WAS
                                          PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.
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                              B21 = THE CHARGES WERE REDUCED BECAUSE THE SERVICE/CARE
                                    WAS PARTIALLY FURNISHED BY ANOTHER PHYSICIAN.
                                    INACTIVE
                              B22 = THIS CLAIM/SERVICE IS ADJUSTED BASED ON THE
                                    DIAGNOSIS.
                              B23 = CLAIM/SERVICE DENIED BECAUSE THIS PROVIDER HAS
                                    FAILED AN ASPECT OF A PROFICIENCY TESTING PROGRAM.
                              W1 = WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

1       REV_CNTR_APC_TB               REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                              0001 = PHOTOCHEMOTHERAPY
                              0002 = FINE NEEDLE BIOPSY/ASPIRATION
                              0003 = BONE MARROW BIOPSY/ASPIRATION
                              0004 = LEVEL I NEEDLE BIOPSY/ ASPIRATION EXCEPT
                                       BONE MARROW
                              0005 = LEVEL II NEEDLE BIOPSY /ASPIRATION EXCEPT
                                       BONE MARROW
                              0006 = LEVEL I INCISION & DRAINAGE
                              0007 = LEVEL II INCISION & DRAINAGE
                              0008 = LEVEL III INCISION & DRAINAGE
                              0009 = NAIL PROCEDURES
                              0010 = LEVEL I DESTRUCTION OF LESION
                              0011 = LEVEL II DESTRUCTION OF LESION
                              0012 = LEVEL I DEBRIDEMENT & DESTRUCTION
                              0013 = LEVEL II DEBRIDEMENT & DESTRUCTION
                              0014 = LEVEL III DEBRIDEMENT & DESTRUCTION
                              0015 = LEVEL IV DEBRIDEMENT & DESTRUCTION
                              0016 = LEVEL V DEBRIDEMENT & DESTRUCTION
                              0017 = LEVEL VI DEBRIDEMENT & DESTRUCTION
                              0018 = BIOPSY SKIN, SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE
                              0019 = LEVEL I EXCISION/ BIOPSY
                              0020 = LEVEL II EXCISION/ BIOPSY
                              0021 = LEVEL III EXCISION/ BIOPSY
                              0022 = LEVEL IV EXCISION/ BIOPSY
                              0023 = EXPLORATION PENETRATING WOUND
                              0024 = LEVEL I SKIN REPAIR
                              0025 = LEVEL II SKIN REPAIR
                              0026 = LEVEL III SKIN REPAIR
                              0027 = LEVEL IV SKIN REPAIR
                              0029 = INCISION/EXCISION BREAST
                              0030 = BREAST RECONSTRUCTION/MASTECTOMY
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                              0031 = HYPERBARIC OXYGEN
                              0032 = PLACEMENT TRANSVENOUS CATHETERS/ARTERIAL CUTDOWN
                              0033 = PARTIAL HOSPITALIZATION
                              0040 = ARTHROCENTESIS & LIGAMENT/TENDON INJECTION
                              0041 = ARTHROSCOPY
                              0042 = ARTHROSCOPICALLY-AIDED PROCEDURES
                              0043 = CLOSED TREATMENT FRACTURE FINGER/TOE/TRUNK
                              0044 = CLOSED TREATMENT FRACTURE/DISLOCATION EXCEPT
                                     FINGER/TOE/TRUNK
                              0045 = BONE/JOINT MANIPULATION UNDER ANESTHESIA
                              0046 = OPEN/PERCUTANEOUS TREATMENT FRACTURE OR DISLOCATION
                              0047 = ARTHROPLASTY WITHOUT PROSTHESIS
                              0048 = ARTHROPLASTY WITH PROSTHESIS
                              0049 = LEVEL I MUSCULOSKELETAL PROCEDURES EXCEPT HAND
                                     AND FOOT
                              0050 = LEVEL II MUSCULOSKELETAL PROCEDURES EXCEPT HAND
                                     AND FOOT
                              0051 = LEVEL III MUSCULOSKELETAL PROCEDURES EXCEPT HAND
                                     AND FOOT
                              0052 = LEVEL IV MUSCULOSKELETAL PROCEDURES EXCEPT HAND
                                     AND FOOT
                              0053 = LEVEL I HAND MUSCULOSKELETAL PROCEDURES
                              0054 = LEVEL II HAND MUSCULOSKELETAL PROCEDURES
                              0055 = LEVEL I FOOT MUSCULOSKELETAL PROCEDURES
                              0056 = LEVEL II FOOT MUSCULOSKELETAL PROCEDURES
                              0057 = BUNION PROCEDURES
 1      REV_CNTR_APC_TB               REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                              0058 = LEVEL I STRAPPING AND CAST APPLICATION
                              0059 = LEVEL II STRAPPING AND CAST APPLICATION
                              0060 = MANIPULATION THERAPY
                              0070 = THORACENTESIS/LAVAGE PROCEDURES
                              0071 = LEVEL I ENDOSCOPY UPPER AIRWAY
                              0072 = LEVEL II ENDOSCOPY UPPER AIRWAY
                              0073 = LEVEL III ENDOSCOPY UPPER AIRWAY
                              0074 = LEVEL IV ENDOSCOPY UPPER AIRWAY
                              0075 = LEVEL V ENDOSCOPY UPPER AIRWAY
                              0076 = ENDOSCOPY LOWER AIRWAY
                              0077 = LEVEL I PULMONARY TREATMENT
                              0078 = LEVEL II PULMONARY TREATMENT
                              0079 = VENTILATION INITIATION AND MANAGEMENT
                              0080 = DIAGNOSTIC CARDIAC CATHETERIZATION
                              0081 = NON-CORONARY ANGIOPLASTY OR ATHERECTOMY
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                          0082 = CORONARY ATHERECTOMY
                          0083 = CORONARY ANGIOSPLASTY
                          0084 = LEVEL I ELECTROPHYSIOLOGIC EVALUATION
                          0085 = LEVEL II ELECTROPHYSIOLOGIC EVALUATION
                          0086 = ABLATE HEART DYSRHYTHM FOCUS
                          0087 = CARDIAC ELECTROPHYSIOLOGIC RECORDING/MAPPING
                          0088 = THROMBECTOMY
                          0089 = LEVEL I IMPLANTATION/REMOVAL/REVISION OF PACEMAKER,
                                   AICD VASCULAR DEVICE
                          0090 = LEVEL II IMPLANTATION/REMOVAL/REVISION OF PACEMAKER,
                                   AICD VASCULAR DEVICE
                          0091 = LEVEL I VASCULAR LIGATION
                          0092 = LEVEL II VASCULAR LIGATION
                          0093 = VASCULAR REPAIR/FISTULA CONSTRUCTION
                          0094 = RESUSCITATION AND CARDIOVERSION
                          0095 = CARDIAC REHABILITATION
                          0096 = NON-INVASIVE VASCULAR STUDIES
                          0097 = CARDIOVASCULAR STRESS TEST
                          0098 = INJECTION OF SCLEROSING SOLUTION
                          0099 = CONTINUOUS CARDIAC MONITORING
                          0100 = CONTINUOUS ECG
                          0101 = TILT TABLE EVALUATION
                          0102 = ELECTRONIC ANALYSIS OF PACEMAKERS/OTHER DEVICES
                          0109 = BONE MARROW HARVESTING AND BONE MARROW/STEM CELL
                                   TRANSPLANT
                          0110 = TRANSFUSION
                          0111 = BLOOD PRODUCT EXCHANGE
                          0112 = EXTRACORPOREAL PHOTOPHERESIS
                          0113 = EXCISION LYMPHATIC SYSTEM
                          0114 = THYROID/LYMPHADENECTOMY PROCEDURES
                          0116 = CHEMOTHERAPY ADMINISTRATION BY OTHER TECHNIQUE
                                   EXCEPT INFUSION
                          0117 = CHEMOTHERAPY ADMINISTRATION BY INFUSION ONLY
                          0118 = CHEMOTHERAPY ADMINISTRATION BY BOTH INFUSION AND
                                   OTHER TECHNIQUE
                          0120 = INFUSION THERAPY EXCEPT CHEMOTHERAPY
                          0121 = LEVEL I TUBE CHANGES AND REPOSITIONING
                          0122 = LEVEL II TUBE CHANGES AND REPOSITIONING
                          0123 = LEVEL III TUBE CHANGES AND REPOSITIONING
                          0130 = LEVEL I LAPAROSCOPY
                          0131 = LEVEL II LAPAROSCOPY
                          0132 = LEVEL III LAPAROSCOPY
                          0140 = ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
  1      REV_CNTR_APC_TB                REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                                     0141 = UPPER GI PROCEDURES
                                     0142 = SMALL INTESTINE ENDOSCOPY
                                     0143 = LOWER GI ENDOSCOPY
                                     0144 = DIAGNOSTIC ANOSCOPY
                                     0145 = THERAPEUTIC ANOSCOPY
                                     0146 = LEVEL I SIGMOIDOSCOPY
                                     0147 = LEVEL II SIGMOIDOSCOPY
                                     0148 = LEVEL I ANAL/RECTAL PROCEDURE
                                     0149 = LEVEL II ANAL/RECTAL PROCEDURE
                                     0150 = LEVEL III ANAL/RECTAL PROCEDURE
                                     0151 = ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (ERCP)
                                     0152 = PERCUTANEOUS BILIARY ENDOSCOPIC PROCEDURES
                                     0153 = PERITONEAL AND ABDOMINAL PROCEDURES
                                     0154 = HERNIA/HYDROCELE PROCEDURES
                                     0157 = COLORECTAL CANCER SCREENING: BARIUM ENEMA
                                              (NOT SUBJECT TO NATIONAL COINSURANCE)
                                     0158 = COLORECTAL CANCER SCREENING: COLONOSCOPY
                                              NOT SUBJECT TO NATIONAL COINSURANCE.  MINIMUM
                                              UNADJUSTED COINSURANCE IS 25% OF THE PAYMENT RATE.
                                              PAYMENT RATE IS LOWER OF THE HOPD PAYMENT RATE OR
                                              THE AMBULATORY SURGICAL CENTER PAYMENT.
                                     0159 = COLORECTAL CANCER SCREENING: FLEXIBLE SIGMOIDOSCOPY
                                              NOT SUBJECT TO NATIONAL COINSURANCE.  MINIMUM
                                              UNADJUSTED COINSURANCE IS 25% OF THE PAYMENT RATE.
                                              PAYMENT RATE IS LOWER OF THE HOPD PAYMENT RATE OR
                                              THE AMBULATORY SURGICAL CENTER PAYMENT.
                                     0160 = LEVEL I CYSTOURETHROSCOPY AND OTHER GENITOURINARY
                                              PROCEDURES
                                     0161 = LEVEL II CYSTOURETHROSCOPY AND OTHER GENITOURINARY
                                              PROCEDURES
                                     0162 = LEVEL III CYSTOURETHROSCOPY AND OTHER GENITOURINARY
                                              PROCEDURES
                                     0163 = LEVEL IV CYSTOURETHROSCOPY AND OTHER GENITOURINARY
                                              PROCEDURES
                                     0164 = LEVEL I  URINARY AND ANAL PROCEDURES
                                     0165 = LEVEL II  URINARY AND ANAL PROCEDURES
                                     0166 = LEVEL I URETHRAL PROCEDURES
                                     0167 = LEVEL II URETHRAL PROCEDURES
                                     0168 = LEVEL III URETHRAL PROCEDURES
                                     0169 = LITHOTRIPSY
                                     0170 = DIALYSIS FOR OTHER THAN ESRD PATIENTS
                                     0180 = CIRCUMCISION
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                                0181 = PENILE PROCEDURES
                                0182 = INSERTION OF PENILE PROSTHESIS
                                0183 = TESTES/EPIDIDYMIS PROCEDURES
                                0184 = PROSTATE BIOPSY
                                0190 = SURGICAL HYSTEROSCOPY
                                0191 = LEVEL I FEMALE REPRODUCTIVE PROCEDURES
                                0192 = LEVEL II FEMALE REPRODUCTIVE PROCEDURES
                                0193 = LEVEL III FEMALE REPRODUCTIVE PROCEDURES
                                0194 = LEVEL IV FEMALE REPRODUCTIVE PROCEDURES
                                0195 = LEVEL V FEMALE REPRODUCTIVE PROCEDURES
                                0196 = DILATATION & CURETTAGE
                                0197 = INFERTILITY PROCEDURES
                                0198 = PREGNANCY AND NEONATAL CARE PROCEDURES
                                0199 = VAGINAL DELIVERY
                                0200 = THERAPEUTIC ABORTION
                                0201 = SPONTANEOUS ABORTION
 1      REV_CNTR_APC_TB                REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                                0210 = SPINAL TAP
                                0211 = LEVEL I NERVOUS SYSTEM INJECTIONS
                                0212 = LEVEL II NERVOUS SYSTEM INJECTIONS
                                0213 = EXTENDED EEG STUDIES AND SLEEP STUDIES
                                0214 = ELECTROENCEPHALOGRAM
                                0215 = LEVEL I NERVE AND MUSCLE TESTS
                                0216 = LEVEL II NERVE AND MUSCLE TESTS
                                0217 = LEVEL III NERVE AND MUSCLE TESTS
                                0220 = LEVEL I NERVE PROCEDURES
                                0221 = LEVEL II NERVE PROCEDURES
                                0222 = IMPLANTATION OF NEUROLOGICAL DEVICE
                                0223 = LEVEL I REVISION/REMOVAL NEUROLOGICAL DEVICE
                                0224 = LEVEL II REVISION/REMOVAL NEUROLOGICAL DEVICE
                                0225 = IMPLANTATION OF NEUROSTIMULATOR ELECTRODES
                                0230 = LEVEL I EYE TESTS
                                0231 = LEVEL II EYE TESTS
                                0232 = LEVEL I ANTERIOR SEGMENT EYE
                                0233 = LEVEL II ANTERIOR SEGMENT EYE
                                0234 = LEVEL III ANTERIOR SEGMENT EYE PROCEDURES
                                0235 = LEVEL I POSTERIOR SEGMENT EYE PROCEDURES
                                0236 = LEVEL II POSTERIOR SEGMENT EYE PROCEDURES
                                0237 = LEVEL III POSTERIOR SEGMENT EYE PROCEDURES
                                0238 = LEVEL I REPAIR AND PLASTIC EYE PROCEDURES
                                0239 = LEVEL II REPAIR AND PLASTIC EYE PROCEDURES
                                0240 = LEVEL III REPAIR AND PLASTIC EYE PROCEDURES
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                              0241 = LEVEL IV REPAIR AND PLASTIC EYE PROCEDURES
                              0242 = LEVEL V REPAIR AND PLASTIC EYE PROCEDURES
                              0243 = STRABISMUS/MUSCLE PROCEDURES
                              0244 = CORNEAL TRANSPLANT
                              0245 = CATARACT PROCEDURES WITHOUT IOL INSERT
                              0246 = CATARACT PROCEDURES WITH IOL INSERT
                              0247 = LASER EYE PROCEDURES EXCEPT RETINAL
                              0248 = LASER RETINAL PROCEDURES
                              0250 = NASAL CAUTERIZATION/PACKING
                              0251 = LEVEL I ENT PROCEDURES
                              0252 = LEVEL II ENT PROCEDURES
                              0253 = LEVEL III ENT PROCEDURES
                              0254 = LEVEL IV ENT PROCEDURES
                              0256 = LEVEL V ENT PROCEDURES
                              0257 = IMPLANTATION OF COCHLEAR DEVICE
                              0258 = TONSIL AND ADENOID PROCEDURES
                              0260 = LEVEL I PLAIN FILM EXCEPT TEETH
                              0261 = LEVEL II PLAIN FILM EXCEPT TEETH INCLUDING BONE
                                       DENSITY MEASUREMENT
                              0262 = PLAIN FILM OF TEETH
                              0263 = LEVEL I MISCELLANEOUS RADIOLOGY PROCEDURES
                              0264 = LEVEL II MISCELLANEOUS RADIOLOGY PROCEDURES
                              0265 = LEVEL I DIAGNOSTIC ULTRASOUND EXCEPT VASCULAR
                              0266 = LEVEL II DIAGNOSTIC ULTRASOUND EXCEPT VASCULAR
                              0267 = VASCULAR ULTRASOUND
                              0268 = GUIDANCE UNDER ULTRASOUND
                              0269 = ECHOCARDIOGRAM EXCEPT TRANSESOPHAGEAL
                              0270 = TRANSESOPHAGEAL ECHOCARDIOGRAM
                              0271 = MAMMOGRAPHY
                              0272 = LEVEL I FLUOROSCOPY
                              0273 = LEVEL II FLUOROSCOPY
                              0274 = MYELOGRAPHY
                              0275 = ARTHROGRAPHY
  1      REV_CNTR_APC_TB               REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                              0276 = LEVEL I DIGESTIVE RADIOLOGY
                              0277 = LEVEL II DIGESTIVE RADIOLOGY
                              0278 = DIAGNOSTIC UROGRAPHY
                              0279 = LEVEL I DIAGNOSTIC ANGIOGRAPHY AND VENOGRAPHY
                                       EXCEPT EXTREMITY
                              0280 = LEVEL II DIAGNOSTIC ANGIOGRAPHY AND VENOGRAPHY
                                       EXCEPT EXTREMITY
                              0281 = VENOGRAPHY OF EXTREMITY
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0282 = LEVEL I COMPUTERIZED AXIAL TOMOGRAPHY
0283 = LEVEL II COMPUTERIZED AXIAL TOMOGRAPHY
0284 = MAGNETIC RESONANCE IMAGING
0285 = POSITRON EMISSION TOMOGRAPHY (PET)
0286 = MYOCARDIAL SCANS
0290 = STANDARD NON-IMAGING NUCLEAR MEDICINE
0291 = LEVEL I DIAGNOSTIC NUCLEAR MEDICINE EXCLUDING
       MYOCARDIAL SCANS
0292 = LEVEL II DIAGNOSTIC NUCLEAR MEDICINE EXCLUDING
       MYOCARDIAL SCANS
0294 = LEVEL I THERAPEUTIC NUCLEAR MEDICINE
0295 = LEVEL II THERAPEUTIC NUCLEAR MEDICINE
0296 = LEVEL I THERAPEUTIC RADIOLOGIC PROCEDURES
0297 = LEVEL II THERAPEUTIC RADIOLOGIC PROCEDURES
0300 = LEVEL I RADIATION THERAPY
0301 = LEVEL II RADIATION THERAPY
0302 = LEVEL III RADIATION THERAPY
0303 = TREATMENT DEVICE CONSTRUCTION
0304 = LEVEL  I THERAPEUTIC RADIATION TREATMENT
       PREPARATION
0305 = LEVEL II THERAPEUTIC RADIATION TREATMENT
       PREPARATION
0310 = LEVEL III THERAPEUTIC RADIATION TREATMENT
       PREPARATION
0311 = RADIATION PHYSICS SERVICES
0312 = RADIOELEMENT APPLICATIONS
0313 = BRACHYTHERAPY
0314 = HYPERTHERMIC THERAPIES
0320 = ELECTROCONVULSIVE THERAPY
0321 = BIOFEEDBACK AND OTHER TRAINING
0322 = BRIEF INDIVIDUAL PSYCHOTHERAPY
0323 = EXTENDED INDIVIDUAL PSYCHOTHERAPY
0324 = FAMILY PSYCHOTHERAPY
0325 = GROUP PSYCHOTHERAPY
0330 = DENTAL PROCEDURES
0340 = MINOR ANCILLARY PROCEDURES
0341 = IMMUNOLOGY TESTS
0342 = LEVEL I PATHOLOGY
0343 = LEVEL II PATHOLOGY
0344 = LEVEL III PATHOLOGY
0354 = ADMINISTRATION OF INFLUENZA VACCINE (NOT
       SUBJECT TO NATIONAL COINSURANCE)
0355 = LEVEL I IMMUNIZATIONS
0356 = LEVEL II IMMUNIZATIONS
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                                   0357 = LEVEL III IMMUNIZATIONS
                                   0358 = LEVEL IV IMMUNIZATIONS
                                   0359 = INJECTIONS
                                   0360 = LEVEL I ALIMENTARY TESTS
                                   0361 = LEVEL II ALIMENTARY TESTS
                                   0362 = FITTING OF VISION AIDS
  1      REV_CNTR_APC_TB                  REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                                   0363 = OTORHINOLARYNGOLOGIC FUNCTION TESTS
                                   0364 = LEVEL I AUDIOMETRY
                                   0365 = LEVEL II AUDIOMETRY
                                   0366 = ELECTROCARDIOGRAM (ECG)
                                   0367 = LEVEL I PULMONARY TEST
                                   0368 = LEVEL II PULMONARY TEST
                                   0369 = LEVEL III PULMONARY TEST
                                   0370 = ALLERGY TESTS
                                   0371 = ALLERGY INJECTIONS
                                   0372 = THERAPEUTIC PHLEBOTOMY
                                   0373 = NEUROPSYCHOLOGICAL TESTING
                                   0374 = MONITORING PSYCHIATRIC DRUGS
                                   0600 = LOW LEVEL CLINIC VISITS
                                   0601 = MID LEVEL CLINIC VISITS
                                   0602 = HIGH LEVEL CLINIC VISITS
                                   0603 = INTERDISCIPLINARY TEAM CONFERENCE
                                   0610 = LOW LEVEL EMERGENCY VISITS
                                   0611 = MID LEVEL EMERGENCY VISITS
                                   0612 = HIGH LEVEL EMERGENCY VISITS
                                   0620 = CRITICAL CARE
                                   0701 = STRONTIUM (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                   0702 = SAMARIAM (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                   0704 = SATUMOMAB PENDETIDE (ELIGIBLE FOR PASS-THROUGH
                                          PAYMENTS)
                                   0705 = TC99 TETROFOSMIN (ELIGIBLE FOR PASS-THROUGH
                                          PAYMENTS)
                                   0725 = LEUCOVORIN CALCIUM (ELIGIBLE FOR PASS-THROUGH
                                          PAYMENTS)
                                   0726 = DEXRAZOXANE HYDROCHLORIDE (ELIGIBLE FOR PASS-)
                                          THROUGH PAYMENTS)
                                   0727 = INJECTION, ETIDRONATE DISODIUM (ELIGIBLE FOR
                                          PASS-THROUGH PAYMENTS)
                                   0728 = FILGRASTIM (G-CSF) (ELIGIBLE FOR PASS-THROUGH
                                          PAYMENTS)
                                   0730 = PAMIDRONATE DISODIUM (ELIGIBLE FOR PASS-THROUGH
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                                                   PAYMENTS)
                                     0731 = SARGRAMOSTIM (GM-CSF) (ELIGIBLE FOR PASS-THROUGH
                                                   PAYMENTS)
                                     0732 = MESNA (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                     0733 = EPOETIN ALPHA (ELIGIBLE FOR PASS-THROUGH)
                                                   PAYMENTS)
                                     0750 = DOLASETRON MESYLATE 10 MG (ELIGIBLE FOR PASS-
                                                   THROUGH PAYMENTS)
                                     0754 = METOCLOPRAMIDE HCL (ELIGIBLE FOR PASS-THROUGH
                                                   PAYMENTS)
                                     0755 = THIETHYLPERAZINE MALEATE (ELIGIBLE FOR PASS-THROUGH
                                                   PAYMENTS)
                                     0761 = ORAL SUBSTITUTE FOR IV ANTIEMTIC (ELIGIBLE FOR PASS-
                                                   THROUGH PAYMENTS)
                                     0762 = DRONABINOL (ELIBIBLE FOR PASS-THROUGH PAYMENTS)
                                     0763 = DOLASETRON MESYLATE 100 MG ORAL (ELIGIBLE FOR
                                                   PASS-THROUGH PAYMENTS)
                                     0764 = GRANISETRON HCL, 100 MCG (ELIGIBLE FOR PASS-
                                                   THROUGH PAYMENTS)
                                     0765 = GRANISETRON HCL, 1MG ORAL (ELIGIBLE FOR PASS-
                                                   THROUGH PAYMENTS)
                                     0768 = ONDANSETRON HYDROCHLORIDE PER 1 MG INJECTION
                                                   (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
  1        REV_CNTR_APC_TB                  REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                                     0769 = ONDANSETRON HYDROCHLORIDE 8 MG ORAL
                                                   (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                     0800 = LEUPROLIDE ACETATE PER 3.75 MG (ELIGIBLE FOR
                                                   PASS-THROUGH PAYMENTS)
                                     0801 = CYCLOPHOSPHAMIDE (ELIGIBLE FOR PASS-THROUGH
                                                   PAYMENTS)
                                     0802 = ETOPOSIDE (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                     0803 = MELPHALAN (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                     0807 = ALDESLEUKIN SINGLE USE VIAL (ELIGIBLE FOR PASS-
                                                   THROUGH PAYMENTS)
                                     0809 = BCG (INTRAVESICAL) ONE VIAL (ELIGIBLE FOR PASS-
                                                   THROUGH PAYMENTS)
                                     0810 = GOSERELIN ACETATE IMPLANT, PER 3.6 MG (ELIGIBLE FOR
                                                   PASS-THROUGH PAYMENTS)
                                     0811 = CARBOPLATIN 50 MG (ELIGIBLE FOR PASS-THROUGH
                                                   PAYMENTS)
                                     0812 = CARMUSTINE 100 MG (ELIGIBLE FOR PASS-THROUGH
                                                   PAYMENTS)
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                              0813 = CISPLATIN 10 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0814 = ASPARAGINASE, 10,000 UNITS (ELIGIBLE FOR PASS-
                                     THROUGH PAYMENTS)
                              0815 = CYCLOPHOSPHAMIDE 100 MG (ELIGIBLE FOR PASS-
                                     THROUGH PAYMENTS)
                              0816 = CYCLOPHOSPHAMIDE, LYOPHILIZED 100 MG (ELIGIBLE
                                     FOR PASS-THROUGH PAYMENTS)
                              0817 = CYTRABINE 100 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0818 = DACTINOMYCIN 0.5 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0819 = DACARBAZINE 100 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0820 = DAUNORUBICIN HCI 10 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0821 = DAUNORUBICIN CITRATE, LIPOSOMAL FORMULATION, 10 MG
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0822 = DIETHYLSTIBESTROL DIPHOSPHATE 250 MG
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0823 = DOCETAXEL 20 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0824 = ETOPOSIDE 10 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0826 = METHOTREXATE ORAL 2.5 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0827 = FLOXURIDINE 500 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0828 = GEMCITABINE HCL 200 MG (ELIGIBILE FOR PASS-
                                     THROUGH PAYMENTS)
                              0830 = IRINOTECAN 20 MG (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0831 = IFOSFAMIDE PER 1 GRAM (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0832 = IDARUBICIN HYDROCHLORIDE 5 MG (ELIGIBLE FOR PASS-
                                     THROUGH PAYMENTS)
                              0833 = INTERFERON ALFACON-1, RECOMBINANT, 1 MCG
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0834 = INTERFERON,  ALFA-2A, RECOMBINANT 3 MILLION UNITS
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
  1      REV_CNTR_APC_TB               REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                              0836 = INTERFERON,  ALFA-2B, RECOMBINANT, 1 MILLION UNITS
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                      (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0838 = INTERFERON, GAMMA 1-B, 3 MILLION UNITS
                      (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0839 = MECHLORETHAMINE HCI 10 MG
                      (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0840 = MELPHALAN HCI 50 MG (ELIGIBLE FOR PASS-
                      THROUGH PAYMENTS)
           0841 = METHOTREXATE SODIUM 5 MG (ELIGIBLE FOR PASS-
                      THROUGH PAYMENTS)
           0842 = FLUDARABINE PHOSPHATE 50 MG (ELIGIBLE FOR PASS-
                      THROUGH PAYMENTS)
           0843 = PEGASPARGASE PER SINGLE DOSE VIAL (ELIGIBLE FOR
                      PASS-THROUGH PAYMENTS)
           0844 = PENTOSTATIN 10 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0847 = DOXORUBICIN HCL 10 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0849 = RITUXIMAB, 100 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0850 = STREPTOZOCIN 1 GM (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0851 = THIOTEPA 15 MG (ELIGIBLE FOR PASS-THROUGH PAY-
                      MENTS)
           0852 = TOPOTECAN 4 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0853 = VINBLASTINE SULFATE 1 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0854 = VINCRISTINE SULFATE 1 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0855 = VINORELBINE TARTRATE PER 10 MG (ELIGIBLE FOR PASS-
                      THROUGH PAYMENTS)
           0856 = PORFIMER SODIUM 75 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0857 = BLEOMYCIN SULFATE 15 UNITS (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0858 = CLADRIBINE, 1MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0859 = FLUOROURACIL (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0860 = PLICAMYCIN 2.5 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0861 = LEUPROLIDE ACETATE 1 MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0862 = MITOMYCIN, 5MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0863 = PACLITAXEL, 30MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
           0864 = MITOXANTRONE HCL,  PER 5MG (ELIGIBLE FOR PASS-THROUGH
                      PAYMENTS)
           0865 = INTERFERON ALFA-N3, 250,000 IU (ELIGIBLE FOR PASS-
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                                        THROUGH PAYMENTS)
                              0884 = RHO (D) IMMUNE GLOBULIN, HUMAN ONE DOSE PACK
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0886 = AZATHIOPRINE,  50 MG ORAL
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0887 = AZATHIOPRINE, PARENTERAL 100 MG, 20 ML EACH INJECTION
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0888 = CYCLOSPORINE, ORAL 100 MG
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0889 = CYCLOSPORINE, PARENTERAL
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0890 = LYMPHOCYTE IMMUNE GLOBULIN 50 MG/ ML, 5 ML EACH
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
  1        REV_CNTR_APC_TB                REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                              0891 = TACROLIMUS PER 1 MG ORAL
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0892 = DACLIZUMAB, PARENTERAL, 25 MG
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0900 = INJECTION, ALGLUCERASE PER 10 UNITS
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0901 = ALPHA I, PROTEINASE INHIBITOR, HUMAN PER 10MG
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0902 = BOTULINUM TOXIN, TYPE A PER UNIT
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0903 = CMV IMMUNE GLOBULIN
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0905 = IMMUNE GLOBULIN PER 500 MG
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0906 = RSV IMMUNE GLOBULIN
                                        (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0907 = GANCICLOVIR SODIUM 500 MG INJECTION
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0908 = TETANUS IMMUNE GLOBULIN, HUMAN, UP TO 250 UNITS
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0909 = INTERFERON BETA - 1A   33 MCG (ELIGIBLE FOR PASS-
                                        THROUGH PAYMENTS)
                              0910 = INTERFERON BETA - 1B   0.25 MG (ELIGIBLE FOR PASS-
                                        THROUGH PAYMENTS)
                              0911 = STREPTOKINASE PER 250,000 IU
                                        (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0913 = GANCICLOVIR 4.5  MG, IMPLANT (ELIGIBLE FOR PASS-
                                        THROUGH PAYMENTS)
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                              0914 = RETEPLASE, 37.6 MG (TWO SINGLE USE VIALS)
                                     (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0915 = ALTEPLASE RECOMBINANT, 10MG
                                     (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0916 = IMIGLUCERASE PER UNIT (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0917 = DIPYRIDAMOLE, 10MG / ADENOSINE 6MG
                                     (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0918 = BRACHYTHERAPY SEEDS, ANY TYPE, EACH (ELIGIBLE
                                     FOR PASS-THROUGH PAYMENTS)
                              0925 = FACTOR VIII (ANTIHEMOPHILIC FACTOR, HUMAN) PER IU
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0926 = FACTOR VIII (ANTIHEMOPHILIC FACTOR, PORCINE) PER  IU
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0927 = FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT)
                                     PER IU (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0928 = FACTOR IX,  COMPLEX (ELIGIBLE FOR PASS-THROUGH
                                     PAYMENTS)
                              0929 = OTHER HEMOPHILIA CLOTTING FACTORS PER IU (ELIGIBLE
                                     FOR PASS-THROUGH PAYMENTS)
                              0930 = ANTITHROMBIN III (HUMAN) PER IU (ELIGIBLE FOR PASS-
                                     THROUGH PAYMENTS)
                              0931 = FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-
                                     RECOMBINANT) (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0932 = FACTOR IX (ANTIHEMOPHILIC FACTOR, RECOMBINANT)
                                     (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                              0949 = PLASMA, POOLED MULTIPLE DONOR, SOLVENT/DETERGENT
                                     TREATED, FROZEN (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0950 = BLOOD (WHOLE) FOR TRANSFUSION (NOT SUBJECT TO
                                     NATIONAL COINSURANCE)
 1       REV_CNTR_APC_TB               REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                              0952 = CRYOPRECIPITATE (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0953 = FIBRINOGEN UNIT (NOT SUBJECT TO NATIONAL COINSURANCE)
                              0954 = LEUKOCYTE POOR BLOOD (NOT SUBJECT TO NATIONAL
                                     COINSURANCE)
                              0955 = PLASMA, FRESH FROZEN (NOT SUBJECT TO NATIONAL
                                     COINSURANCE)
                              0956 = PLASMA PROTEIN FRACTION (NOT SUBJECT TO NATIONAL
                                     COINSURANCE)
                              0957 = PLATELET CONCENTRATE (NOT SUBJECT TO NATIONAL
                                     COINSURANCE)
                              0958 = PLATELET RICH PLASMA (NOT SUBJECT TO NATIONAL
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                         COINSURANCE)
              0959 = RED BLOOD CELLS (NOT SUBJECT TO NATIONAL COINSURANCE)
              0960 = WASHED RED BLOOD CELLS (NOT SUBJECT TO NATIONAL
                         COINSURANCE)
              0961 = INFUSION, ALBUMIN (HUMAN) 5%, 500 ML
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0962 = INFUSION, ALBUMIN (HUMAN) 25%, 50 ML
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0970 = NEW TECHNOLOGY - LEVEL I       ($0 - $50)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0971 = NEW TECHNOLOGY - LEVEL II      ($50 - $100)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0972 = NEW TECHNOLOGY - LEVEL III     ($100 - $200)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0973 = NEW TECHNOLOGY - LEVEL IV      ($200 - $300)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0974 = NEW TECHNOLOGY - LEVEL V       ($300 - $500)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0975 = NEW TECHNOLOGY - LEVEL VI      ($500 - $750)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0976 = NEW TECHNOLOGY - LEVEL VII     ($750 - $1000)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0977 = NEW TECHNOLOGY - LEVEL VIII    ($1000 - $1250)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0978 = NEW TECHNOLOGY - LEVEL IX      ($1250 - $1500)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0979 = NEW TECHNOLOGY - LEVEL X       ($1500 - $1750)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0980 = NEW TECHNOLOGY - LEVEL XI      ($1750 - $2000)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0981 = NEW TECHNOLOGY - LEVEL XII     ($2000 - $2500)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0982 = NEW TECHNOLOGY - LEVEL XIII    ($2500 - $3500)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0983 = NEW TECHNOLOGY - LEVEL XIV     ($3500 - $5000)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              0984 = NEW TECHNOLOGY - LEVEL XV      ($5000 - $6000)
                         (NOT SUBJECT TO NATIONAL COINSURANCE)
              7000 = AMIFOSTINE, 500 MG (ELIGIBLE FOR PASS-THROUGH
                         PAYMENTS)
              7001 = AMPHOTERICIN B LIPID COMPLEX, 50 MG, INJ
                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
              7002 = CLONIDINE, HCL, 1 MG (ELIGIBLE FOR PASS-
                         THROUGH PAYMENTS)
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                                  7003 = EPOPROSTENOL, 0.5 MG, INJ (ELIGIBLE FOR PASS-
                                         THROUGH PAYMENTS)
                                  7004 = IMMUNE GLOBULIN INTRAVENOUS HUMAN 5G, INJ
1       REV_CNTR_APC_TB                  REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7005 = GONADORELIN HCI, 100 MCG (ELIGIBLE FOR PASS-
                                         THROUGH PAYMENTS)
                                  7007 = MILRINONE LACETATE, PER 5 ML, INJ (NOT SUBJECT
                                         TO NATIONAL COINSURANCE)
                                  7010 = MORPHINE SULFATE CONCENTRATE (PRESERVATIVE FREE)
                                         PER 10 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7011 = OPRELEVEKIN, INJ, 5 MG (ELIGIBLE FOR PASS-THROUGH
                                         PAYMENTS)
                                  7012 = PENTAMIDINE ISETHIONATE, 300 MG (ELIGIBLE FOR
                                         PASS-THROUGH PAYMENTS)
                                  7014 = FENTANYL CITRATE, INJ, UP TO 2 ML (ELIGIBLE FOR
                                         PASS-THROUGH PAYMENTS)
                                  7015 = BUSULFAN, ORAL 2 MG (ELIGIBLE FOR PASS-THROUGH
                                         PAYMENTS)
                                  7019 = APROTININ, 10,000 KIU (ELIGIBLE FOR PASS-THROUGH
                                         PAYMENTS)
                                  7021 = BACLOFEN, INTRATHECAL, 50 MCG (ELIGIBLE FOR PASS-
                                         THROUGH PAYMENTS)
                                  7022 = ELLIOTTS B SOLUTION, PER ML (ELIGIBLE FOR PASS-
                                         THROUGH PAYMENTS)
                                  7023 = TREATMENT FOR BLADDER CALCULI, I.E. RENACIDIN
                                         PER 500 ML (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7024 = CORTICORELIN OVINE TRIFLUTATE, 0.1 MG
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7025 = DIGOXIN IMMUNE FAB (OVINE), 10 MG
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7026 = ETHANOLAMINE OLEATE, 1000 ML
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7027 = FOMEPIZOLE, 1.5 G
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7028 = FOSPHENYTOIN, 50 MG
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7029 = GLATIRAMER ACETATE, 25 MG
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7030 = HEMIN, 1 MG
                                         (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                                  7031 = OCTREOTIDE ACETATE, 500 MCG
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                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7032 = SERMORELIN ACETATE, 0.5 MG
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7033 = SOMATREM, 5 MG
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7034 = SOMATROPIN, 1 MG
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7035 = TENIPOSIDE, 50 MG
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7036 = UROKINASE, INJ, IV, 250,000 I.U.
                                    (NOT SUBJECT TO NATIONAL COINSURANCE)
                             7037 = UROFOLLITROPIN, 75 I.U.
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7038 = MUROMONAB-CD3, 5 MG
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7039 = PEGADEMASE BOVINE INJ 25 I.U.
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7040 = PENTASTARCH 10% INJ, 100 ML
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7041 = TIROFIBAN HCL, 0.5 MG
 1       REV_CNTR_APC_TB              REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)
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                                    (NOT SUBJECT TO NATIONAL COINSURANCE)
                             7042 = CAPECITABINE, ORAL 150 MG
                                    (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
                             7043 = INFLIXIMAB, 10 MG (ELIGIBLE FOR PASS-THROUGH
                                    PAYMENTS)
                             7045 = TRIMETREXATE GLUCORONATE (ELIGIBLE FOR PASS-
                                    THROUGH PAYMENTS)
                             7046 = DOXORUBICIN HCL LIPOSOME (ELIGIBLE FOR PASS-
                                    THROUGH PAYMENTS)

 1 REV_CNTR_DDCTBL_COINSRNC_TB                REVENUE CENTER DEDUCTIBLE COINSURANCE CODE
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                             0 = CHARGES ARE SUBJECT TO DEDUCTIBLE
                                 AND COINSURANCE
                             1 = CHARGES ARE NOT SUBJECT TO DEDUCTIBLE
                             2 = CHARGES ARE NOT SUBJECT TO COINSURANCE
                             3 = CHARGES ARE NOT SUBJECT TO DEDUCTIBLE
                                 OR COINSURANCE
                             4 = NO CHARGE OR UNITS ASSOCIATED WITH THIS
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                              REVENUE CENTER CODE.  (FOR MULTIPLE
                              HCPCS PER SINGLE REVENUE CENTER CODE)

                         FOR REVENUE CENTER CODE 0001, THE FOLLOWING
                         MSP OVERRIDE VALUES MAY BE PRESENT:

                         M = OVERRIDE CODE; EGHP SERVICES INVOLVED
                             (EFF 12/90 FOR NON-INSTITUTIONAL CLAIMS;
                             10/93 FOR INSTITUTIONAL CLAIMS)
                         N = OVERRIDE CODE; NON-EGHP SERVICES INVOLVED
                             (EFF 12/90 FOR NON-INSTITUTIONAL CLAIMS;
                             10/93 FOR INSTITUTIONAL CLAIMS)
                         X = OVERRIDE CODE: MSP COST AVOIDED
                             (EFF 12/90 FOR NON-INSTITUTIONAL CLAIMS;
                             10/93 FOR INSTITUTIONAL CLAIMS)

  1   REV_CNTR_PMT_MTHD_IND_TB              REVENUE CENTER PAYMENT METHOD INDICATOR TABLE
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                         **********SERVICE INDICATOR**************
                         ********** 1ST POSITION *****************
                         A = SERVICES NOT PAID UNDER OPPS
                         C = INPATIENT PROCEDURE
                         E = NONCOVERED ITEMS OR SERVICES
                         F = CORNEAL ISSUE ACQUISTION
                         G = CURRENT DRUG OR BIOLOGICAL PASS-THROUGH
                         H = DEVICE PASS-THROUGH
                         J = NEW DRUG OR NEW BIOLOGICAL PASS-THROUGH
                         N = PACKAGED INCIDENTAL SERVICE
                         P = PARTIAL HOSPITALIZATION SERVICES
                         S = SIGNIFICANT PROCEDURE NOT SUBJECT TO
                             MULTIPLE PROCEDURE DISCOUNTING
                         T = SIGNIFICANT PROCEDURE SUBJECT TO MULTIPLE
                             PROCEDURE DISCOUNTING
                         V = MEDICAL VISIT TO CLINIC OR EMERGENCY
                             DEPARTMENT
                         X = ANCILLARY SERVICE

                         **********PAYMENT INDICATOR**************
                         ********** 2ND POSITION *****************
                         1 = PAID STANDARD HOSPITAL OPPS AMOUNT
                             (SERVICE INDICATORS S,T,V,X)
                         2 = SERVICES NOT PAID UNDER OPPS (SERVICE
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                              INDICATOR A, OR NO HCPCS CODE AND NOT
                              CERTAIN REVENUE CENTER CODES)
                        3 = NOT PAID (SERVICE INDICATORS C & E)
                        4 = ACQUISITION COST PAID (SERVICE INDICA-
                              TOR F)
                        5 = ADDITIONAL PAYMENT FOR CURRENT DRUG OR
                              BIOLOGICAL (SERVICE INDICATOR G)
                        6 = ADDITIONAL PAYMENT FOR DEVICE (SERVICE
                              INDICATOR H)
                        7 = ADDITIONAL PAYMENT FOR NEW DRUG OR NEW
                              BIOLOGICAL (SERVICE INDICATOR J)
                        8 = PAID PARTIAL HOSPITALIZATION PER DIEM
                              (SERVICE INDICATOR P)
                        9 = NO ADDITIONAL PAYMENT, PAYMENT INCLUDED
                              IN LINE ITEMS WITH APCS (SERVICE
                              INDICATOR N, OR NO HCPCS CODE AND CERTAIN
                              REVENUE CENTER CODES, OR HCPCS CODES Q0082
                              (ACTIVITY THERAPY), G0129 (OCCUPATIONAL
                              THERAPY) OR G0172 (PARTIAL HOSPITALIZATION
                              TRAINING)
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  1    REV_CNTR_PRICNG_IND_TB                    REVENUE CENTER PRICING INDICATOR TABLE
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                        A = A VALID HCPCS CODE NOT SUBJECT TO A FEE SCHEDULE PAYMENT.
                              REIMBURSEMENT IS CALCULATED ON PROVIDER SUBMITTED
                              CHARGES.
                        B = A VALID HCPCS CODE SUBJECT TO THE FEE SCHEDULE PAYMENT.
                              REIMBURSEMENT IS THE LESSER OF PROVIDER SUBMITTED
                              CHARGES OR THE FEE SCHEDULE AMOUNT.
                        D = A VALID RADIOLOGY HCPCS CODE SUBJECT TO THE RADIOLOGY
                              PRICER AND THE RATE IS REFLECTED AS ZEROES ON THE HCPCS
                              FILE AND COST REPORT.  THE RADIOLOGY PRICER TREATS THIS
                              HCPCS AS A NON-COVERED SERVICE.  REIMBURSEMENT IS CAL-
                              CULATED ON PROVIDER SUBMITTED CHARGES.
                        E = A VALID ASC HCPCS CODE SUBJECT TO THE ASC PRICER. THE
                              RATE IS REFLECTED AS ZEROES ON THE HCPCS FILE.  THE
                              ASC PRICER DETERMINES THE ASC PAYMENT RATE AND IS RE-
                              PORTED ON THE COST REPORT.
                        F = A VALID ESRD HCPCS CODE SUBJECT TO THE PARAMETER RATE.
                              REIMBURSEMENT IS THE LESSER OF PROVIDER SUBMITTED
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                                      CHARGES OR THE FEE SCHEDULE AMOUNT FOR NON-DIALYSIS
HCPCS. REIMBURSEMENT IS CALCULATED ON THE PROVIDER
FILE RATES FOR DIALYSIS HCPCS.

G = A VALID HCPCS, CODE IS SUBJECT TO A FEE SCHEDULE, BUT
    THE RATE IS NO LONGER PRESENT ON THE HCPCS FILE.
    REIMBURSEMENT IS CALCULATED ON PROVIDER SUBMITTED
    CHARGES.

H = A VALID DME HCPCS, CODE IS SUBJECT TO A FEE SCHEDULE.
    THE RATES ARE REFLECTED UNDER THE DME SEGMENT. REIM-
    BURSEMENT IS CALCULATED EITHER ON A FEE SCHEDULE, PRO-
    VIDER SUBMITTED CHARGES OR THE LESSER OF PROVIDER
    SUBMITTED, OR THE FEE SCHEDULE DEPENDING O THE CATE-
    GORY.

I = A VALID DME CATEGORY 5 HCPCS, HCPCS IS NOT FOUND ON
    THE DME HISTORY RECORD, BUT A MATCH WAS FOUND ON HIC,
    CATEGORY AND GENERIC CODE. CLAIM MUST BE REVIEWED BY
    MEDICAL REVIEW BEFORE PAYMENT CAN BE CALCULATED.

J = A VALID DME HCPCS, NO DME HISTORY IS PRESENT, AND A
    PRESCRIPTION IS REQUIRED BEFORE DELIVERY. CLAIM MUST
    BE REVIEWED BY MEDICAL REVIEW.

K = A VALID DME HCPCS, PRESCRIBED HAS BEEN REVIEWED, AND
    FEE SCHEDULE PAYMENT IS APPROVED AS PRESCRIPTION WAS
    PRESENT BEFORE DELIVERY.

L = A VALID TENS HCPCS, RENTAL PERIOD IS SIX MONTHS OR
    GREATER AND MUST BE REVIEWED BY MEDICAL REVIEW.

M = A VALID TENS HCPCS, MEDICAL REVIEW HAS APPROVED THE
    RENTAL CHARGE IN EXCESS OF FIVE MONTHS.

R = A VALID RADIOLOGY HCPCS CODE AND IS SUBJECT TO THE
    RADIOLOGY PRICER. THE RATE IS REPORTED ON THE COST
    REPORT. REIMBURSEMENT IS CALCULATED ON PROVIDER
    SUBMITTED CHARGES.

S = VALID INFLUENZA/PPV HCPCS. A FEE AMOUNT IS NOT
    APPLICABLE. THE AMOUNT PAYABLE IS PRESENT IN THE
    COVERED CHARGE FIELD. THIS AMOUNT IS NOT SUBJECT
    TO THE COINSURANCE AND DEDUCTIBLE. THIS CHARGE IS
    SUBJECT TO THE PROVIDER'S REIMBURSEMENT RATE.

T = VALID HCPCS. A FEE AMOUNT IS PRESENT. THE AMOUNT
    PAYABLE SHOULD BE THE LOWER OF THE BILLED CHARGE OR

1   REV_CNTR_PRICNG_IND_TB   REVENUE CENTER PRICING INDICATOR TABLE
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                                        FEE AMOUNT. THE SYSTEM SHOULD COMPUTE THE FEE AMOUNT
BY MULTIPLYING THE COVERED UNITS TIMES THE RATE.
THE FEE AMOUNT IS NOT SUBJECT TO COINSURANCE AND

DEDUCTIBLE OR PROVIDER'S REIMBURSEMENT RATE.

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1        REV_CNTR_TB                        REVENUE CENTER TABLE
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                         0001 = TOTAL CHARGE
                         0022 = SNF CLAIM PAID UNDER PPS SUBMITTED AS TOB 21X,
                                EFFECTIVE FOR COST REPORTING PERIODS BEGIN-
                                NING ON OR AFTER 7/1/98 (DATES OF SERVICE AFTER
                                6/30/98).  NOTE:  THIS CODE MAY APPEAR MULTIPLE
                                TIMES ON A CLAIM TO IDENTIFY DIFFERENT HIPPS
                                RATE CODE/ASSESSMENT PERIODS.
                         0023 = HOME HEALTH SERVICES PAID UNDER PPS SUBMITTED AS
                                TOB 32X AND 33X, EFFECTIVE 10/00.  THIS CODE MAY
                                APPEAR MULTIPLE TIMES ON A CLAIM TO IDENTIFY
                                DIFFERENT HIPPS/HOME HEALTH RESOURCE GROUPS (HRG).
                         0100 = ALL INCLUSIVE RATE-ROOM AND BOARD PLUS ANCILLARY
                         0101 = ALL INCLUSIVE RATE-ROOM AND BOARD
                         0110 = PRIVATE MEDICAL OR GENERAL-GENERAL CLASSIFICATION
                         0111 = PRIVATE MEDICAL OR GENERAL-MEDICAL/SURGICAL/GYN
                         0112 = PRIVATE MEDICAL OR GENERAL-OB
                         0113 = PRIVATE MEDICAL OR GENERAL-PEDIATRIC
                         0114 = PRIVATE MEDICAL OR GENERAL-PSYCHIATRIC
                         0115 = PRIVATE MEDICAL OR GENERAL-HOSPICE
                         0116 = PRIVATE MEDICAL OR GENERAL-DETOXIFICATION
                         0117 = PRIVATE MEDICAL OR GENERAL-ONCOLOGY
                         0118 = PRIVATE MEDICAL OR GENERAL-REHABILITATION
                         0119 = PRIVATE MEDICAL OR GENERAL-OTHER
                         0120 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
                                GENERAL CLASSIFICATION
                         0121 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
                                MEDICAL/SURGICAL/GYN
                         0122 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-OB
                         0123 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-PEDIATRIC
                         0124 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-PSYCHIATRIC
                         0125 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-HOSPICE
                         0126 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
                                DETOXIFICATION
                         0127 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-ONCOLOGY
                         0128 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
                                REHABILITATION
                         0129 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-OTHER
                         0130 = SEMI-PRIVATE 3 AND 4 BEDS-GENERAL CLASSIFICATION
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                              0131 = SEMI-PRIVATE 3 AND 4 BEDS-MEDICAL/SURGICAL/GYN
                              0132 = SEMI-PRIVATE 3 AND 4 BEDS-OB
                              0133 = SEMI-PRIVATE 3 AND 4 BEDS-PEDIATRIC
                              0134 = SEMI-PRIVATE 3 AND 4 BEDS-PSYCHIATRIC
                              0135 = SEMI-PRIVATE 3 AND 4 BEDS-HOSPICE
                              0136 = SEMI-PRIVATE 3 AND 4 BEDS-DETOXIFICATION
                              0137 = SEMI-PRIVATE 3 AND 4 BEDS-ONCOLOGY
                              0138 = SEMI_PRIVATE 3 AND 4 BEDS-REHABILITATION
                              0139 = SEMI-PRIVATE 3 AND 4 BEDS-OTHER
                              0140 = PRIVATE (DELUXE)-GENERAL CLASSIFICATION
                              0141 = PRIVATE (DELUXE)-MEDICAL/SURGICAL/GYN
                              0142 = PRIVATE (DELUXE)-OB
                              0143 = PRIVATE (DELUXE)-PEDIATRIC
                              0144 = PRIVATE (DELUXE)-PSYCHIATRIC
                              0145 = PRIVATE (DELUXE)-HOSPICE
                              0146 = PRIVATE (DELUXE)-DETOXIFICATION
                              0147 = PRIVATE (DELUXE)-ONCOLOGY
                              0148 = PRIVATE (DELUXE)-REHABILITATION
                              0149 = PRIVATE (DELUXE)-OTHER
1        REV_CNTR_TB                                  REVENUE CENTER TABLE
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                              0150 = ROOM&BOARD WARD (MEDICAL OR GENERAL)
                                     GENERAL CLASSIFICATION
                              0151 = ROOM&BOARD WARD (MEDICAL OR GENERAL)
                                     MEDICAL/SURGICAL/GYN
                              0152 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-OB
                              0153 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-PEDIATRIC
                              0154 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-PSYCHIATRIC
                              0155 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-HOSPICE
                              0156 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-DETOXIFICATION
                              0157 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-ONCOLOGY
                              0158 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-REHABILITATION
                              0159 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-OTHER
                              0160 = OTHER ROOM&BOARD-GENERAL CLASSIFICATION
                              0164 = OTHER ROOM&BOARD-STERILE ENVIRONMENT
                              0167 = OTHER ROOM&BOARD-SELF CARE
                              0169 = OTHER ROOM&BOARD-OTHER
                              0170 = NURSERY-GENERAL CLASSIFICATION
                              0171 = NURSERY-NEWBORN
                                     LEVEL I (ROUTINE)
                              0172 = NURSERY-PREMATURE
                                     NEWBORN-LEVEL II (CONTINUING CARE)
                              0173 = NURSERY-NEWBORN-LEVEL III (INTERMEDIATE CARE)
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                                            (EFF 10/96)
                        0174 = NURSERY-NEWBORN-LEVEL IV (INTENSIVE CARE)
                                (EFF 10/96)
                        0175 = NURSERY-NEONATAL ICU (OBSOLETE EFF 10/96)
                        0179 = NURSERY-OTHER
                        0180 = LEAVE OF ABSENCE-GENERAL CLASSIFICATION
                        0182 = LEAVE OF ABSENCE-PATIENT CONVENIENCE CHARGES
                                BILLABLE
                        0183 = LEAVE OF ABSENCE-THERAPEUTIC LEAVE
                        0184 = LEAVE OF ABSENCE-ICF MENTALLY RETARDED-ANY REASON
                        0185 = LEAVE OF ABSENCE-NURSING HOME (HOSPITALIZATION)
                        0189 = LEAVE OF ABSENCE-OTHER LEAVE OF ABSENCE
                        0190 = SUBACUTE CARE - GENERAL CLASSIFICATION
                                (EFF. 10/97)
                        0191 = SUBACUTE CARE - LEVEL I (EFF. 10/97)
                        0192 = SUBACUTE CARE - LEVEL II (EFF. 10/97)
                        0193 = SUBACUTE CARE - LEVEL III (EFF. 10/97)
                        0194 = SUBACUTE CARE - LEVEL IV (EFF. 10/97)
                        0199 = SUBACUTE CARE - OTHER (EFF 10/97)
                        0200 = INTENSIVE CARE-GENERAL CLASSIFICATION
                        0201 = INTENSIVE CARE-SURGICAL
                        0202 = INTENSIVE CARE-MEDICAL
                        0203 = INTENSIVE CARE-PEDIATRIC
                        0204 = INTENSIVE CARE-PSYCHIATRIC
                        0206 = INTENSIVE CARE-POST ICU; REDEFINED AS
                                INTERMEDIATE ICU (EFF 10/96)
                        0207 = INTENSIVE CARE-BURN CARE
                        0208 = INTENSIVE CARE-TRAUMA
                        0209 = INTENSIVE CARE-OTHER INTENSIVE CARE
                        0210 = CORONARY CARE-GENERAL CLASSIFICATION
                        0211 = CORONARY CARE-MYOCARDIAL INFRACTION
                        0212 = CORONARY CARE-PULMONARY CARE
                        0213 = CORONARY CARE-HEART TRANSPLANT
                        0214 = CORONARY CARE-POST CCU; REDEFINED AS
                                INTERMEDIATE CCU (EFF 10/96)
                        0219 = CORONARY CARE-OTHER CORONARY CARE
1          REV_CNTR_TB                       REVENUE CENTER TABLE
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                        0220 = SPECIAL CHARGES-GENERAL CLASSIFICATION
                        0221 = SPECIAL CHARGES-ADMISSION CHARGE
                        0222 = SPECIAL CHARGES-TECHNICAL SUPPORT CHARGE
                        0223 = SPECIAL CHARGES-UR SERVICE CHARGE
                        0224 = SPECIAL CHARGES-LATE DISCHARGE, MEDICALLY
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                              NECESSARY
              0229 = SPECIAL CHARGES-OTHER SPECIAL CHARGES
              0230 = INCREMENTAL NURSING CHARGE RATE-GENERAL
                     CLASSIFICATION
              0231 = INCREMENTAL NURSING CHARGE RATE-NURSERY
              0232 = INCREMENTAL NURSING CHARGE RATE-OB
              0233 = INCREMENTAL NURSING CHARGE RATE-ICU (INCLUDE
                     TRANSITIONAL CARE)
              0234 = INCREMENTAL NURSING CHARGE RATE-CCU (INCLUDE
                     TRANSITIONAL CARE)
              0235 = INCREMENTAL NURSING CHARGE RATE-HOSPICE
              0239 = INCREMENTAL NURSING CHARGE RATE-OTHER
              0240 = ALL INCLUSIVE ANCILLARY-GENERAL CLASSIFICATION
              0241 = ALL INCLUSIVE ANCILLARY-BASIC
              0242 = ALL INCLUSIVE ANCILLARY-COMPREHENSIVE
              0243 = ALL INCLUSIVE ANCILLARY-SPECIALTY
              0249 = ALL INCLUSIVE ANCILLARY-OTHER INCLUSIVE ANCILLARY
              0250 = PHARMACY-GENERAL CLASSIFICATION
              0251 = PHARMACY-GENERIC DRUGS
              0252 = PHARMACY-NONGENERIC DRUGS
              0253 = PHARMACY-TAKE HOME DRUGS
              0254 = PHARMACY-DRUGS INCIDENT TO OTHER DIAGNOSTIC SERVICE-
                     SUBJECT TO PAYMENT LIMIT
              0255 = PHARMACY-DRUGS INCIDENT TO RADIOLOGY-
                     SUBJECT TO PAYMENT LIMIT
              0256 = PHARMACY-EXPERIMENTAL DRUGS
              0257 = PHARMACY-NON-PRESCRIPTION
              0258 = PHARMACY-IV SOLUTIONS
              0259 = PHARMACY-OTHER PHARMACY
              0260 = IV THERAPY-GENERAL CLASSIFICATION
              0261 = IV THERAPY-INFUSION PUMP
              0262 = IV THERAPY-PHARMACY SERVICES (EFF 10/94)
              0263 = IV THERAPY-DRUG SUPPLY/DELIVERY (EFF 10/94)
              0264 = IV THERAPY-SUPPLIES (EFF 10/94)
              0269 = IV THERAPY-OTHER IV THERAPY
              0270 = MEDICAL/SURGICAL SUPPLIES-GENERAL CLASSIFICATION
                     (ALSO SEE 062X)
              0271 = MEDICAL/SURGICAL SUPPLIES-NONSTERILE SUPPLY
              0272 = MEDICAL/SURGICAL SUPPLIES-STERILE SUPPLY
              0273 = MEDICAL/SURGICAL SUPPLIES-TAKE HOME SUPPLIES
              0274 = MEDICAL/SURGICAL SUPPLIES-PROSTHETIC/ORTHOTIC
                     DEVICES
              0275 = MEDICAL/SURGICAL SUPPLIES-PACE MAKER
              0276 = MEDICAL/SURGICAL SUPPLIES-INTRAOCULAR LENS
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                            0277 = MEDICAL/SURGICAL SUPPLIES-OXYGEN-TAKE HOME
                            0278 = MEDICAL/SURGICAL SUPPLIES-OTHER IMPLANTS
                            0279 = MEDICAL/SURGICAL SUPPLIES-OTHER DEVICES
                            0280 = ONCOLOGY-GENERAL CLASSIFICATION
                            0289 = ONCOLOGY-OTHER ONCOLOGY
                            0290 = DME (OTHER THAN RENAL)-GENERAL CLASSIFICATION
                            0291 = DME (OTHER THAN RENAL)-RENTAL
                            0292 = DME (OTHER THAN RENAL)-PURCHASE OF NEW DME
                            0293 = DME (OTHER THAN RENAL)-PURCHASE OF USED DME
1          REV_CNTR_TB                         REVENUE CENTER TABLE
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                            0294 = DME (OTHER THAN RENAL)-RELATED TO AND LISTED AS DME
                            0299 = DME (OTHER THAN RENAL)-OTHER
                            0300 = LABORATORY-GENERAL CLASSIFICATION
                            0301 = LABORATORY-CHEMISTRY
                            0302 = LABORATORY-IMMUNOLOGY
                            0303 = LABORATORY-RENAL PATIENT (HOME)
                            0304 = LABORATORY-NON-ROUTINE DIALYSIS
                            0305 = LABORATORY-HEMATOLOGY
                            0306 = LABORATORY-BACTERIOLOGY & MICROBIOLOGY
                            0307 = LABORATORY-UROLOGY
                            0309 = LABORATORY-OTHER LABORATORY
                            0310 = LABORATORY PATHOLOGICAL-GENERAL CLASSIFICATION
                            0311 = LABORATORY PATHOLOGICAL-CYTOLOGY
                            0312 = LABORATORY PATHOLOGICAL-HISTOLOGY
                            0314 = LABORATORY PATHOLOGICAL-BIOPSY
                            0319 = LABORATORY PATHOLOGICAL-OTHER
                            0320 = RADIOLOGY DIAGNOSTIC-GENERAL CLASSIFICATION
                            0321 = RADIOLOGY DIAGNOSTIC-ANGIOCARDIOGRAPHY
                            0322 = RADIOLOGY DIAGNOSTIC-ARTHROGRAPHY
                            0323 = RADIOLOGY DIAGNOSTIC-ARTERIOGRAPHY
                            0324 = RADIOLOGY DIAGNOSTIC-CHEST X-RAY
                            0329 = RADIOLOGY DIAGNOSTIC-OTHER
                            0330 = RADIOLOGY THERAPEUTIC-GENERAL CLASSIFICATION
                            0331 = RADIOLOGY THERAPEUTIC-CHEMOTHERAPY INJECTED
                            0332 = RADIOLOGY THERAPEUTIC-CHEMOTHERAPY ORAL
                            0333 = RADIOLOGY THERAPEUTIC-RADIATION THERAPY
                            0335 = RADIOLOGY THERAPEUTIC-CHEMOTHERAPY IV
                            0339 = RADIOLOGY THERAPEUTIC-OTHER
                            0340 = NUCLEAR MEDICINE-GENERAL CLASSIFICATION
                            0341 = NUCLEAR MEDICINE-DIAGNOSTIC
                            0342 = NUCLEAR MEDICINE-THERAPEUTIC
                            0349 = NUCLEAR MEDICINE-OTHER
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                              0350 = COMPUTED TOMOGRAPHIC (CT) SCAN-GENERAL
                                     CLASSIFICATION
                              0351 = CT SCAN-HEAD SCAN
                              0352 = CT SCAN-BODY SCAN
                              0359 = CT SCAN-OTHER CT SCANS
                              0360 = OPERATING ROOM SERVICES-GENERAL CLASSIFICATION
                              0361 = OPERATING ROOM SERVICES-MINOR SURGERY
                              0362 = OPERATING ROOM SERVICES-ORGAN TRANSPLANT,
                                     OTHER THAN KIDNEY
                              0367 = OPERATING ROOM SERVICES-KIDNEY TRANSPLANT
                              0369 = OPERATING ROOM SERVICES-OTHER OPERATING ROOM
                                     SERVICES
                              0370 = ANESTHESIA-GENERAL CLASSIFICATION
                              0371 = ANESTHESIA-INCIDENT TO RAD AND
                                     SUBJECT TO THE PAYMENT LIMIT
                              0372 = ANESTHESIA-INCIDENT TO OTHER DIAGNOSTIC SERVICE
                                     AND SUBJECT TO THE PAYMENT LIMIT
                              0374 = ANESTHESIA-ACUPUNCTURE
                              0379 = ANESTHESIA-OTHER ANESTHESIA
                              0380 = BLOOD-GENERAL CLASSIFICATION
                              0381 = BLOOD-PACKED RED CELLS
                              0382 = BLOOD-WHOLE BLOOD
                              0383 = BLOOD-PLASMA
                              0384 = BLOOD-PLATELETS
                              0385 = BLOOD-LEUKOCYTES
                              0386 = BLOOD-OTHER COMPONENTS
  1         REV_CNTR_TB                               REVENUE CENTER TABLE
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                              0387 = BLOOD-OTHER DERIVATIVES (CRYOPRICIPATATES)
                              0389 = BLOOD-OTHER BLOOD
                              0390 = BLOOD STORAGE AND PROCESSING-GENERAL
                                     CLASSIFICATION
                              0391 = BLOOD STORAGE AND PROCESSING-BLOOD
                                     ADMINISTRATION
                              0399 = BLOOD STORAGE AND PROCESSING-OTHER
                              0400 = OTHER IMAGING SERVICES-GENERAL CLASSIFICATION
                              0401 = OTHER IMAGING SERVICES-DIAGNOSTIC MAMMOGRAPHY
                              0402 = OTHER IMAGING SERVICES-ULTRASOUND
                              0403 = OTHER IMAGING SERVICES-SCREENING MAMMOGRAPHY
                                     (EFF 1/1/91)
                              0404 = OTHER IMAGING SERVICES-POSITRON EMISSION
                                     TOMOGRAPHY (EFF 10/94)
                              0409 = OTHER IMAGING SERVICES-OTHER
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                         0410 = RESPIRATORY SERVICES-GENERAL CLASSIFICATION
                         0412 = RESPIRATORY SERVICES-INHALATION SERVICES
                         0413 = RESPIRATORY SERVICES-HYPERBARIC OXYGEN THERAPY
                         0419 = RESPIRATORY SERVICES-OTHER
                         0420 = PHYSICAL THERAPY-GENERAL CLASSIFICATION
                         0421 = PHYSICAL THERAPY-VISIT CHARGE
                         0422 = PHYSICAL THERAPY-HOURLY CHARGE
                         0423 = PHYSICAL THERAPY-GROUP RATE
                         0424 = PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION
                         0429 = PHYSICAL THERAPY-OTHER
                         0430 = OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION
                         0431 = OCCUPATIONAL THERAPY-VISIT CHARGE
                         0432 = OCCUPATIONAL THERAPY-HOURLY CHARGE
                         0433 = OCCUPATIONAL THERAPY-GROUP RATE
                         0434 = OCCUPATIONAL THERAPY-EVALUATION OR RE-EVALUATION
                         0439 = OCCUPATIONAL THERAPY-OTHER (MAY INCLUDE
                                RESTORATIVE THERAPY)
                         0440 = SPEECH LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION
                         0441 = SPEECH LANGUAGE PATHOLOGY-VISIT CHARGE
                         0442 = SPEECH LANGUAGE PATHOLOGY-HOURLY CHARGE
                         0443 = SPEECH LANGUAGE PATHOLOGY-GROUP RATE
                         0444 = SPEECH LANGUAGE PATHOLOGY-EVALUATION OR
                                RE-EVALUATION
                         0449 = SPEECH LANGUAGE PATHOLOGY-OTHER
                         0450 = EMERGENCY ROOM-GENERAL CLASSIFICATION
                         0451 = EMERGENCY ROOM-EMTALA EMERGENCY MEDICAL SCREENING
                                SERVICES (EFF 10/96)
                         0452 = EMERGENCY ROOM-ER BEYOND EMTALA SCREENING
                                (EFF 10/96)
                         0456 = EMERGENCY ROOM-URGENT CARE (EFF 10/96)
                         0459 = EMERGENCY ROOM-OTHER
                         0460 = PULMONARY FUNCTION-GENERAL CLASSIFICATION
                         0469 = PULMONARY FUNCTION-OTHER
                         0470 = AUDIOLOGY-GENERAL CLASSIFICATION
                         0471 = AUDIOLOGY-DIAGNOSTIC
                         0472 = AUDIOLOGY-TREATMENT
                         0479 = AUDIOLOGY-OTHER
                         0480 = CARDIOLOGY-GENERAL CLASSIFICATION
                         0481 = CARDIOLOGY-CARDIAC CATH LAB
                         0482 = CARDIOLOGY-STRESS TEST
                         0483 = CARDIOLOGY-ECHOCARDIOLOGY
                         0489 = CARDIOLOGY-OTHER
                         0490 = AMBULATORY SURGICAL CARE-GENERAL CLASSIFICATION
   1        REV_CNTR_TB                                REVENUE CENTER TABLE
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                              0499 = AMBULATORY SURGICAL CARE-OTHER
                              0500 = OUTPATIENT SERVICES-GENERAL CLASSIFICATION
                                     (DELETED 9/93)
                              0509 = OUTPATIENT SERVICES-OTHER (DELETED 9/93)
                              0510 = CLINIC-GENERAL CLASSIFICATION
                              0511 = CLINIC-CHRONIC PAIN CENTER
                              0512 = CLINIC-DENTAL CENTER
                              0513 = CLINIC-PSYCHIATRIC
                              0514 = CLINIC-OB-GYN
                              0515 = CLINIC-PEDIATRIC
                              0516 = CLINIC-URGENT CARE CLINIC (EFF 10/96)
                              0517 = CLINIC-FAMILY PRACTICE CLINIC (EFF 10/96)
                              0519 = CLINIC-OTHER
                              0520 = FREE-STANDING CLINIC-GENERAL CLASSIFICATION
                              0521 = FREE-STANDING CLINIC-RURAL HEALTH CLINIC
                              0522 = FREE-STANDING CLINIC-RURAL HEALTH HOME
                              0523 = FREE-STANDING CLINIC-FAMILY PRACTICE
                              0526 = FREE-STANDING CLINIC-URGENT CARE (EFF 10/96)
                              0529 = FREE-STANDING CLINIC-OTHER
                              0530 = OSTEOPATHIC SERVICES-GENERAL CLASSIFICATION
                              0531 = OSTEOPATHIC SERVICES-OSTEOPATHIC THERAPY
                              0539 = OSTEOPATHIC SERVICES-OTHER
                              0540 = AMBULANCE-GENERAL CLASSIFICATION
                              0541 = AMBULANCE-SUPPLIES
                              0542 = AMBULANCE-MEDICAL TRANSPORT
                              0543 = AMBULANCE-HEART MOBILE
                              0544 = AMBULANCE-OXYGEN
                              0545 = AMBULANCE-AIR AMBULANCE
                              0546 = AMBULANCE-NEO-NATAL AMBULANCE
                              0547 = AMBULANCE-PHARMACY
                              0548 = AMBULANCE-TELEPHONE TRANSMISSION EKG
                              0549 = AMBULANCE-OTHER
                              0550 = SKILLED NURSING-GENERAL CLASSIFICATION
                              0551 = SKILLED NURSING-VISIT CHARGE
                              0552 = SKILLED NURSING-HOURLY CHARGE
                              0559 = SKILLED NURSING-OTHER
                              0560 = MEDICAL SOCIAL SERVICES-GENERAL CLASSIFICATION
                              0561 = MEDICAL SOCIAL SERVICES-VISIT CHARGE
                              0562 = MEDICAL SOCIAL SERVICES-HOURLY CHARGES
                              0569 = MEDICAL SOCIAL SERVICES-OTHER
                              0570 = HOME HEALTH AID (HOME HEALTH)-GENERAL
                                     CLASSIFICATION
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                               0571 = HOME HEALTH AID (HOME HEALTH)-VISIT CHARGE
                               0572 = HOME HEALTH AID (HOME HEALTH)-HOURLY CHARGE
                               0579 = HOME HEALTH AID (HOME HEALTH)-OTHER
                               0580 = OTHER VISITS (HOME HEALTH)-GENERAL
                                      CLASSIFICATION (UNDER HHPPS, NOT ALLOWED
                                      AS COVERED CHARGES)
                               0581 = OTHER VISITS (HOME HEALTH)-VISIT CHARGE
                                      (UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
                               0582 = OTHER VISITS (HOME HEALTH)-HOURLY CHARGE
                                      (UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
                               0589 = OTHER VISITS (HOME HEALTH)-OTHER
                                      (UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
                               0590 = UNITS OF SERVICE (HOME HEALTH)-GENERAL
                                      CLASSIFICATION (UNDER HHPPS, NOT ALLOWED
                                      AS COVERED CHARGES)
                               0599 = UNITS OF SERVICE (HOME HEALTH)-OTHER
  1         REV_CNTR_TB                        REVENUE CENTER TABLE
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                                      (UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
                               0600 = OXYGEN-GENERAL CLASSIFICATION
                               0601 = OXYGEN-STAT OR PORT EQUIP/SUPPLY OR COUNT
                               0602 = OXYGEN-STAT/EQUIP/UNDER 1 LPM
                               0603 = OXYGEN-STAT/EQUIP/OVER 4 LPM
                               0604 = OXYGEN-STAT/EQUIP/PORTABLE ADD-ON
                               0610 = MAGNETIC RESONANCE TECHNOLOGY (MRT)-GENERAL
                                      CLASSIFICATION
                               0611 = MRT/MRI-BRAIN (INCLUDING BRAINSTEM)
                               0612 = MRT/MRI-SPINAL CORD (INCLUDING SPINE)
                               0614 = MRT/MRI-OTHER
                               0615 = MRT/MRA-HEAD AND NECK
                               0616 = MRT/MRA-LOWER EXTREMITIES
                               0618 = MRT/MRA-OTHER
                               0619 = MRT/OTHER MRI
                               0621 = MEDICAL/SURGICAL SUPPLIES-INCIDENT TO RADIOLOGY-
                                      SUBJECT TO THE PAYMENT LIMIT - EXTENSION OF 027X
                               0622 = MEDICAL/SURGICAL SUPPLIES-INCIDENT TO OTHER
                                      DIAGNOSTIC SERVICE-SUBJECT TO THE PAYMENT LIMIT -
                                      EXTENSION OF 027X
                               0623 = MEDICAL/SURGICAL SUPPLIES-SURGICAL DRESSINGS
                                      (EFF 1/95) - EXTENSION OF 027X
                               0624 = MEDICAL/SURGICAL SUPPLIES-MEDICAL INVESTIGATIONAL
                                      DEVICES AND PROCEDURES WITH FDA APPROVED IDE'S
                                      (EFF 10/96) - EXTENSION OF 027X
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                          0630 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-GENERAL
                                 CLASSIFICATION
                          0631 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-SINGLE DRUG
                                 SOURCE (EFF 9/93)
                          0632 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-MULTIPLE DRUG
                                 SOURCE (EFF 9/93)
                          0633 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-RESTRICTIVE
                                 PRESCRIPTION (EFF 9/93)
                          0634 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-EPO UNDER
                                 10,000 UNITS
                          0635 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-EPO 10,000
                                 UNITS OR MORE
                          0636 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-DETAILED
                                 CODING (EFF 3/92)
                          0637 = SELF-ADMINISTERED DRUGS ADMINISTERED IN AN
                                 EMERGENCY SITUATION - NOT REQUIRING DETAILED
                                 CODING
                          0640 = HOME IV THERAPY-GENERAL CLASSIFICATION
                                 (EFF 10/94)
                          0641 = HOME IV THERAPY-NONROUTINE NURSING
                                 (EFF 10/94)
                          0642 = HOME IV THERAPY-IV SITE CARE, CENTRAL LINE
                                 (EFF 10/94)
                          0643 = HOME IV THERAPY-IV START/CHANGE PERIPHERAL LINE
                                 (EFF 10/94)
                          0644 = HOME IV THERAPY-NONROUTINE NURSING, PERIPHERAL LINE
                                 (EFF 10/94)
                          0645 = HOME IV THERAPY-TRAIN PATIENT/CAREGIVER, CENTRAL
                                 LINE (EFF 10/94)
                          0646 = HOME IV THERAPY-TRAIN DISABLED PATIENT, CENTRAL
                                 LINE (EFF 10/94)
                          0647 = HOME IV THERAPY-TRAIN PATIENT/CAREGIVER, PERIPHERAL
                                 LINE (EFF 10/94)
1          REV_CNTR_TB                                REVENUE CENTER TABLE
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                          0648 = HOME IV THERAPY-TRAIN DISABLED PATIENT, PERIPHERAL
                                 LINE (EFF 10/94)
                          0649 = HOME IV THERAPY-OTHER IV THERAPY SERVICES
                                 (EFF 10/94)
                          0650 = HOSPICE SERVICES-GENERAL CLASSIFICATION
                          0651 = HOSPICE SERVICES-ROUTINE HOME CARE
                          0652 = HOSPICE SERVICES-CONTINUOUS HOME CARE-1/2
                          0655 = HOSPICE SERVICES-INPATIENT CARE
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0656 = HOSPICE SERVICES-GENERAL INPATIENT CARE
       (NON-RESPITE)
0657 = HOSPICE SERVICES-PHYSICIAN SERVICES
0659 = HOSPICE SERVICES-OTHER
0660 = RESPITE CARE (HHA)-GENERAL CLASSIFICATION
       (EFF 9/93)
0661 = RESPITE CARE (HHA)-HOURLY CHARGE/SKILLED NURSING
       (EFF 9/93)
0662 = RESPITE CARE (HHA)-HOURLY CHARGE/HOME HEALTH AIDE/
       HOMEMAKER (EFF 9/93)
0670 = OP SPECIAL RESIDENCE CHARGES - GENERAL
       CLASSIFICATION
0671 = OP SPECIAL RESIDENCE CHARGES - HOSPITAL BASED
0672 = OP SPECIAL RESIDENCE CHARGES - CONTRACTED
0679 = OP SPECIAL RESIDENCE CHARGES - OTHER SPECIAL
       RESIDENCE CHARGES
0700 = CAST ROOM-GENERAL CLASSIFICATION
0709 = CAST ROOM-OTHER
0710 = RECOVERY ROOM-GENERAL CLASSIFICATION
0719 = RECOVERY ROOM-OTHER
0720 = LABOR ROOM/DELIVERY-GENERAL CLASSIFICATION
0721 = LABOR ROOM/DELIVERY-LABOR
0722 = LABOR ROOM/DELIVERY-DELIVERY
0723 = LABOR ROOM/DELIVERY-CIRCUMCISION
0724 = LABOR ROOM/DELIVERY-BIRTHING CENTER
0729 = LABOR ROOM/DELIVERY-OTHER
0730 = EKG/ECG-GENERAL CLASSIFICATION
0731 = EKG/ECG-HOLTER MONITER
0732 = EKG/ECG-TELEMETRY (INCLUDE FETAL MONITERING UNTIL
       9/93)
0739 = EKG/ECG-OTHER
0740 = EEG-GENERAL CLASSIFICATION
0749 = EEG (ELECTROENCEPHALOGRAM)-OTHER
0750 = GASTRO-INTESTINAL SERVICES-GENERAL CLASSIFICATION
0759 = GASTRO-INTESTINAL SERVICES-OTHER
0760 = TREATMENT OR OBSERVATION ROOM-GENERAL
       CLASSIFICATION
0761 = TREATMENT OR OBSERVATION ROOM-TREATMENT ROOM
       (EFF 9/93)
0762 = TREATMENT OR OBSERVATION ROOM-OBSERVATION ROOM
       (EFF 9/93)
0769 = TREATMENT OR OBSERVATION ROOM-OTHER
0770 = PREVENTATIVE CARE SERVICES-GENERAL CLASSIFICATION
       (EFF 10/94)
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                              0771 = PREVENTATIVE CARE SERVICES-VACCINE ADMINISTRATION
                                        (EFF 10/94)
                              0779 = PREVENTATIVE CARE SERVICES-OTHER (EFF 10/94)
                              0780 = TELEMEDICINE - GENERAL CLASSIFICATION
                                        (EFF 10/97)
                              0789 = TELEMEDICINE - TELEMEDICINE (EFF 10/97)
     1         REV_CNTR_TB                          REVENUE CENTER TABLE
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                              0790 = LITHOTRIPSY-GENERAL CLASSIFICATION
                              0799 = LITHOTRIPSY-OTHER
                              0800 = INPATIENT RENAL DIALYSIS-GENERAL CLASSIFICATION
                              0801 = INPATIENT RENAL DIALYSIS-INPATIENT HEMODIALYSIS
                              0802 = INPATIENT RENAL DIALYSIS-INPATIENT PERITONEAL
                                        (NON-CAPD)
                              0803 = INPATIENT RENAL DIALYSIS-INPATIENT CAPD
                              0804 = INPATIENT RENAL DIALYSIS-INPATIENT CCPD
                              0809 = INPATIENT RENAL DIALYSIS-OTHER INPATIENT DIALYSIS
                              0810 = ORGAN ACQUISITION-GENERAL CLASSIFICATION
                              0811 = ORGAN ACQUISITION-LIVING DONOR (EFF 10/94);
                                        PRIOR TO 10/94, DEFINED AS LIVING DONOR KIDNEY
                              0812 = ORGAN ACQUISITION-CADAVER DONOR (EFF 10/94);
                                        PRIOR TO 10/94, DEFINED AS CADAVER DONOR KIDNEY
                              0813 = ORGAN ACQUISITION-UNKNOWN DONOR (EFF 10/94)
                                        PRIOR TO 10/94, DEFINED AS UNKNOWN DONOR KIDNEY
                              0814 = ORGAN ACQUISITION - UNSUCCESSFUL ORGAN SEARCH-
                                        DONOR BANK CHARGES (EFF 10/94); PRIOR TO 10/94,
                                        DEFINED AS OTHER KIDNEY ACQUISITION
                              0815 = ORGAN ACQUISITION-CADAVER DONOR-HEART
                                        (OBSOLETE, EFF 10/94)
                              0816 = ORGAN ACQUISITION-OTHER HEART ACQUISITION
                                        (OBSOLETE, EFF 10/94)
                              0817 = ORGAN ACQUISITION-DONOR-LIVER
                                        (OBSOLETE, EFF 10/94)
                              0819 = ORGAN ACQUISITION-OTHER DONOR (EFF 10/94);
                                        PRIOR TO 10/94, DEFINED AS OTHER
                              0820 = HEMODIALYSIS OP OR HOME DIALYSIS-GENERAL
                                        CLASSIFICATION
                              0821 = HEMODIALYSIS OP OR HOME DIALYSIS-HEMODIALYSIS-
                                        COMPOSITE OR OTHER RATE
                              0822 = HEMODIALYSIS OP OR HOME DIALYSIS-HOME SUPPLIES
                              0823 = HEMODIALYSIS OP OR HOME DIALYSIS-HOME EQUIPMENT
                              0824 = HEMODIALYSIS OP OR HOME DIALYSIS-MAINTENANCE/100%
                              0825 = HEMODIALYSIS OP OR HOME DIALYSIS-SUPPORT SERVICES
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                              0829 = HEMODIALYSIS OP OR HOME DIALYSIS-OTHER
                              0830 = PERITONEAL DIALYSIS OP OR HOME-GENERAL
                                       CLASSIFICATION
                              0831 = PERITONEAL DIALYSIS OP OR HOME-PERITONEAL-
                                       COMPOSITE OR OTHER RATE
                              0832 = PERITONEAL DIALYSIS OP OR HOME-HOME SUPPLIES
                              0833 = PERITONEAL DIALYSIS OP OR HOME-HOME EQUIPMENT
                              0834 = PERITONEAL DIALYSIS OP OR HOME-MAINTENANCE/100%
                              0835 = PERITONEAL DIALYSIS OP OR HOME-SUPPORT SERVICES
                              0839 = PERITONEAL DIALYSIS OP OR HOME-OTHER
                              0840 = CAPD OUTPATIENT-GENERAL CLASSIFICATION
                              0841 = CAPD OUTPATIENT-CAPD/COMPOSITE OR OTHER RATE
                              0842 = CAPD OUTPATIENT-HOME SUPPLIES
                              0843 = CAPD OUTPATIENT-HOME EQUIPMENT
                              0844 = CAPD OUTPATIENT-MAINTENANCE/100%
                              0845 = CAPD OUTPATIENT-SUPPORT SERVICES
                              0849 = CAPD OUTPATIENT-OTHER
                              0850 = CCPD OUTPATIENT-GENERAL CLASSIFICATION
                              0851 = CCPD OUTPATIENT-CCPD/COMPOSITE OR OTHER RATE
                              0852 = CCPD OUTPATIENT-HOME SUPPLIES
                              0853 = CCPD OUTPATIENT-HOME EQUIPMENT
                              0854 = CCPD OUTPATIENT-MAINTENANCE/100%
                              0855 = CCPD OUTPATIENT-SUPPORT SERVICES
1         REV_CNTR_TB                              REVENUE CENTER TABLE
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                              0859 = CCPD OUTPATIENT-OTHER
                              0880 = MISCELLANEOUS DIALYSIS-GENERAL CLASSIFICATION
                              0881 = MISCELLANEOUS DIALYSIS-ULTRAFILTRATION
                              0882 = MISCELLANEOUS DIALYSIS-HOME DIALYSIS AIDE VISIT
                                       (EFF 9/93)
                              0889 = MISCELLANEOUS DIALYSIS-OTHER
                              0890 = OTHER DONOR BANK-GENERAL CLASSIFICATION; CHANGED TO
                                       RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
                              0891 = OTHER DONOR BANK-BONE; CHANGED TO
                                       RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
                              0892 = OTHER DONOR BANK-ORGAN (OTHER THAN KIDNEY); CHANGED
                                       TO RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
                              0893 = OTHER DONOR BANK-SKIN; CHANGED TO
                                       RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
                              0899 = OTHER DONOR BANK-OTHER; CHANGED TO
                                       RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
                              0900 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-GENERAL
                                       CLASSIFICATION
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                              0901 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-ELECTROSHOCK
                                     TREATMENT
                              0902 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-MILIEU
                                     THERAPY
                              0903 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-PLAY
                                     THERAPY
                              0904 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-ACTIVITY
                                     THERAPY (EFF 4/94)
                              0909 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-OTHER
                              0910 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GENERAL
                                     CLASSIFICATION
                              0911 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-REHABILITATION
                              0912 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-DAY CARE-
                                     REDEFINED 10/97 TO LESS INTENSIVE
                              0913 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-NIGHT CARE
                                     REDEFINED 10/97 TO INTENSIVE
                              0914 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-INDIVIDUAL
                                     THERAPY
                              0915 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GROUP THERAPY
                              0916 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-FAMILY THERAPY
                              0917 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-BIOFEEDBACK
                              0918 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-TESTING
                              0919 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-OTHER
                              0920 = OTHER DIAGNOSTIC SERVICES-GENERAL CLASSIFICATION
                              0921 = OTHER DIAGNOSTIC SERVICES-PERIPHERAL VASCULAR LAB
                              0922 = OTHER DIAGNOSTIC SERVICES-ELECTROMYELOGRAM
                              0923 = OTHER DIAGNOSTIC SERVICES-PAP SMEAR
                              0924 = OTHER DIAGNOSTIC SERVICES-ALLERGY TEST
                              0925 = OTHER DIAGNOSTIC SERVICES-PREGNANCY TEST
                              0929 = OTHER DIAGNOSTIC SERVICES-OTHER
                              0940 = OTHER THERAPEUTIC SERVICES-GENERAL CLASSIFICATION
                              0941 = OTHER THERAPEUTIC SERVICES-RECREATIONAL THERAPY
                              0942 = OTHER THERAPEUTIC SERVICES-EDUCATION/TRAINING
                                     (INCLUDE DIABETES DIET TRAINING)
                              0943 = OTHER THERAPEUTIC SERVICES-CARDIAC REHABILITATION
                              0944 = OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION
                              0945 = OTHER THERAPEUTIC SERVICES-ALCOHOL
                                     REHABILITATION
                              0946 = OTHER THERAPEUTIC SERVICES-ROUTINE COMPLEX
                                     MEDICAL EQUIPMENT
 1        REV_CNTR_TB                             REVENUE CENTER TABLE
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                              0947 = OTHER THERAPEUTIC SERVICES-ANCILLARY COMPLEX
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                        MEDICAL EQUIPMENT (EFF 3/92)
             0949 = OTHER THERAPEUTIC SERVICES-OTHER
             0951 = PROFESSIONAL FEES-ATHLETIC TRAINING
             0952 = PROFESSIONAL FEES-KINESIOTHERAPY
             0960 = PROFESSIONAL FEES-GENERAL CLASSIFICATION
             0961 = PROFESSIONAL FEES-PSYCHIATRIC
             0962 = PROFESSIONAL FEES-OPHTHALMOLOGY
             0963 = PROFESSIONAL FEES-ANESTHESIOLOGIST (MD)
             0964 = PROFESSIONAL FEES-ANESTHETIST (CRNA)
             0969 = PROFESSIONAL FEES-OTHER
             0971 = PROFESSIONAL FEES-LABORATORY
             0972 = PROFESSIONAL FEES-RADIOLOGY DIAGNOSTIC
             0973 = PROFESSIONAL FEES-RADIOLOGY THERAPEUTIC
             0974 = PROFESSIONAL FEES-NUCLEAR MEDICINE
             0975 = PROFESSIONAL FEES-OPERATING ROOM
             0976 = PROFESSIONAL FEES-RESPIRATORY THERAPY
             0977 = PROFESSIONAL FEES-PHYSICAL THERAPY
             0978 = PROFESSIONAL FEES-OCCUPATIONAL THERAPY
             0979 = PROFESSIONAL FEES-SPEECH PATHOLOGY
             0981 = PROFESSIONAL FEES-EMERGENCY ROOM
             0982 = PROFESSIONAL FEES-OUTPATIENT SERVICES
             0983 = PROFESSIONAL FEES-CLINIC
             0984 = PROFESSIONAL FEES-MEDICAL SOCIAL SERVICES
             0985 = PROFESSIONAL FEES-EKG
             0986 = PROFESSIONAL FEES-EEG
             0987 = PROFESSIONAL FEES-HOSPITAL VISIT
             0988 = PROFESSIONAL FEES-CONSULTATION
             0989 = PROFESSIONAL FEES-PRIVATE DUTY NURSE
             0990 = PATIENT CONVENIENCE ITEMS-GENERAL CLASSIFICATION
             0991 = PATIENT CONVENIENCE ITEMS-CAFETERIA/GUEST TRAY
             0992 = PATIENT CONVENIENCE ITEMS-PRIVATE LINEN SERVICE
             0993 = PATIENT CONVENIENCE ITEMS-TELEPHONE/TELEGRAPH
             0994 = PATIENT CONVENIENCE ITEMS-TV/RADIO
             0995 = PATIENT CONVENIENCE ITEMS-NONPATIENT ROOM RENTALS
             0996 = PATIENT CONVENIENCE ITEMS-LATE DISCHARGE CHARGE
             0997 = PATIENT CONVENIENCE ITEMS-ADMISSION KITS
             0998 = PATIENT CONVENIENCE ITEMS-BEAUTY SHOP/BARBER
             0999 = PATIENT CONVENIENCE ITEMS-OTHER

             NOTE: FOLLOWING REVENUE CODES REPORTED
             FOR NHCMQ (RUGS) DEMO CLAIMS EFFECTIVE
             2/96.

             9000 = RUGS-NO MDS ASSESSMENT AVAILABLE
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                                      9001 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PA1/ADL INDEX OF 4-5
                                      9002 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PA2/ADL INDEX OF 4-5
                                      9003 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PB1/ADL INDEX OF 6-8
                                      9004 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PB2/ADL INDEX OF 6-8
                                      9005 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PC1/ADL INDEX OF 9-10
                                      9006 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PC2/ADL INDEX OF 9-10
                                      9007 = REDUCED PHYSICAL FUNCTIONS-
  1          REV_CNTR_TB                               REVENUE CENTER TABLE
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                                             RUGS PD1/ADL INDEX OF 11-15
                                      9008 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PD2/ADL INDEX OF 11-15
                                      9009 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PE1/ADL INDEX OF 16-18
                                      9010 = REDUCED PHYSICAL FUNCTIONS-
                                             RUGS PE2/ADL INDEX OF 16-18
                                      9011 = BEHAVIOR ONLY PROBLEMS-
                                             RUGS BA1/ADL INDEX OF 4-5
                                      9012 = BEHAVIOR ONLY PROBLEMS-
                                             RUGS BA2/ADL INDEX OF 4-5
                                      9013 = BEHAVIOR ONLY PROBLEMS-
                                             RUGS BB1/ADL INDEX OF 6-10
                                      9014 = BEHAVIOR ONLY PROBLEMS-
                                             RUGS BB2/ADL INDEX OF 6-10
                                      9015 = IMPAIRED COGNITION-
                                             RUGS IA1/ADL INDEX OF 4-5
                                      9016 = IMPAIRED COGNITION-
                                             RUGS IA2/ADL INDEX OF 4-5
                                      9017 = IMPAIRED COGNITION-
                                             RUGS IB1/ADL INDEX OF 6-10
                                      9018 = IMPAIRED COGNITION-
                                             RUGS IB2/ADL INDEX OF 6-10
                                      9019 = CLINICALLY COMPLEX-
                                             RUGS CA1/ADL INDEX OF 4-5
                                      9020 = CLINICALLY COMPLEX-
                                             RUGS CA2/ADL INDEX OF 4-5D
                                      9021 = CLINICALLY COMPLEX-
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                              RUGS CB1/ADL INDEX OF 6-10
                       9022 = CLINICALLY COMPLEX-
                              RUGS CB2/ADL INDEX OF 6-10D
                       9023 = CLINICALLY COMPLEX-
                              RUGS CC1/ADL INDEX OF 11-16
                       9024 = CLINICALLY COMPLEX-
                              RUGS CC2/ADL INDEX OF 11-16D
                       9025 = CLINICALLY COMPLEX-
                              RUGS CD1/ADL INDEX OF 17-18
                       9026 = CLINICALLY COMPLEX-
                              RUGS CD2/ADL INDEX OF 17-18D
                       9027 = SPECIAL CARE-
                              RUGS SSA/ADL INDEX OF 7-13
                       9028 = SPECIAL CARE-
                              RUGS SSB/ADL INDEX OF 14-16
                       9029 = SPECIAL CARE-
                              RUGS SSC/ADL INDEX OF 17-18
                       9030 = EXTENSIVE SERVICES-
                              RUGS SE1/1 PROCEDURE
                       9031 = EXTENSIVE SERVICES-
                              RUGS SE2/2 PROCEDURES
                       9032 = EXTENSIVE SERVICES-
                              RUGS SE3/3 PROCEDURES
                       9033 = LOW REHABILITATION-
                              RUGS RLA/ADL INDEX OF 4-11
                       9034 = LOW REHABILITATION-
                              RUGS RLB/ADL INDEX OF 12-18
                       9035 = MEDIUM REHABILITATION-
                              RUGS RMA/ADL INDEX OF 4-7
                       9036 = MEDIUM REHABILITATION-
 1         REV_CNTR_TB                          REVENUE CENTER TABLE
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                              RUGS RMB/ADL INDEX OF 8-15
                       9037 = MEDIUM REHABILITATION-
                              RUGS RMC/ADL INDEX OF 16-18
                       9038 = HIGH REHABILITATION-
                              RUGS RHA/ADL INDEX OF 4-7
                       9039 = HIGH REHABILITATION-
                              RUGS RHB/ADL INDEX OF 8-11
                       9040 = HIGH REHABILITATION-
                              RUGS RHC/ADL INDEX OF 12-14
                       9041 = HIGH REHABILITATION-
                              RUGS RHD/ADL INDEX OF 15-18
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9042 = VERY HIGH REHABILITATION-
       RUGS RVA/ADL INDEX OF 4-7
9043 = VERY HIGH REHABILITATION-
       RUGS RVB/ADL INDEX OF 8-13
9044 = VERY HIGH REHABILITATION-
       RUGS RVC/ADL INDEX OF 14-18

***CHANGES EFFECTIVE FOR PROVIDERS ENTERING***
**RUGS DEMO PHASE III AS OF 1/1/97 OR LATER**

9019 = CLINICALLY COMPLEX-
       RUGS CA1/ADL INDEX OF 11
9020 = CLINICALLY COMPLEX-
       RUGS CA2/ADL INDEX OF 11D
9021 = CLINICALLY COMPLEX-
       RUGS CB1/ADL INDEX OF 12-16
9022 = CLINICALLY COMPLEX-
       RUGS CB2/ADL INDEX OF 12-16D
9023 = CLINICALLY COMPLEX-
       RUGS CC1/ADL INDEX OF 17-18
9024 = CLINICALLY COMPLEX-
       RUGS CC2/ADL INDEX OF 17-18D
9025 = SPECIAL CARE-
       RUGS SSA/ADL INDEX OF 14
9026 = SPECIAL CARE-
       RUGS SSB/ADL INDEX OF 15-16
9027 = SPECIAL CARE-
       RUGS SSC/ADL INDEX OF 17-18
9028 = EXTENSIVE SERVICES-
       RUGS SE1/ADL INDEX 7-18/1 PROCEDURE
9029 = EXTENSIVE SERVICES-
       RUGS SE2/ADL INDEX 7-18/2 PROCEDURES
9030 = EXTENSIVE SERVICES-
       RUGS SE3/ADL INDEX 7-18/3 PROCEDURES
9031 = LOW REHABILITATION-
       RUGS RLA/ADL INDEX OF 4-13
9032 = LOW REHABILITATION-
       RUGS RLB/ADL INDEX OF 14-18
9033 = MEDIUM REHABILITATION-
       RUGS RMA/ADL INDEX OF 4-7
9034 = MEDIUM REHABILITATION-
       RUGS RMB/ADL INDEX OF 8-14
9035 = MEDIUM REHABILITATION-
       RUGS RMC/ADL INDEX OF 15-18
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                                        9036 = HIGH REHABILITATION-
                                               RUGS RHA/ADL INDEX OF 4-7
                                        9037 = HIGH REHABILITATION-
1           REV_CNTR_TB                                  REVENUE CENTER TABLE
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                                               RUGS RHB/ADL INDEX OF 8-12
                                        9038 = HIGH REHABILITATION-
                                               RUGS RHC/ADL INDEX OF 13-18
                                        9039 = VERY HIGH REHABILITATION-
                                               RUGS RVA/ADL INDEX OF 4-8
                                        9040 = VERY HIGH REHABILITATION-
                                               RUGS RVB/ADL INDEX OF 9-15
                                        9041 = VERY HIGH REHABILITATION-
                                               RUGS RVC/ADL INDEX OF 16
                                        9042 = VERY HIGH REHABILITATION-
                                               RUGS RUA/ADL INDEX OF 4-8
                                        9043 = VERY HIGH REHABILITATION-
                                               RUGS RUB/ADL INDEX OF 9-15
                                        9044 = ULTRA HIGH REHABILITATION-
                                               RUGS RUC/ADL INDEX OF 16-18
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